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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the top copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3315

CERTIFICATE OF DEATH

03284

Reg. Dist. No. 21

Items 9, 14 Film G182 5-31-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u> MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>ANNE ARUNDEL</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RIVIERA BEACH</u> 14 YEARS		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RIVIERA BEACH</u>	
TOWN <u>RIVIERA BEACH</u>		LENGTH OF STAY (in this place)		TOWN <u>RIVIERA BEACH</u>		STREET ADDRESS (If rural give location) <u>BAY & HARLEM ROADS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>BAY & HARLEM ROADS</u>				STREET ADDRESS <u>BAY & HARLEM ROADS</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MARY ANN BARRETT</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 26 1955</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>April 1, 1863</u>	9. AGE last birthday <u>92</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>IRELAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>EDWARD F. BARRETT</u>				14. MOTHER'S MAIDEN NAME <u>MARY ANN I PATHE H 5614 Lyons</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>MRS. MARY DURNER - RIVIERA BEACH, MD</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1 I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS</u>						IMMEDIATE	
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>						10 YEARS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 1954</u> , to <u>April 26, 1955</u> , that I last saw the deceased alive on <u>April 23, 1955</u> , and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. Brady Smith</u>				ADDRESS (Street, city, town, state) <u>RIVIERA BEACH MD</u>		DATE SIGNED <u>4/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>13</u>		DATE THEREOF <u>4-29-55</u>		NAME OF CEMETERY OR CREMATORY <u>CATHEDRAL</u>		LOCATION (City, town, or county) <u>BALTO</u>	
24. REC'D BY REGISTRAR <u>4/28/55</u>		REGISTRAR'S SIGNATURE <u>Wm. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. L. L. Loney</u>		ADDRESS <u>1305 E. Ford Lane</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

1955



1. NAME OF DECEASED		2. PLACE OF BIRTH	
3. SEX		4. RACE	
5. DATE OF BIRTH		6. DATE OF DEATH	
7. TIME OF DEATH		8. PLACE OF DEATH	
9. CAUSE OF DEATH		10. MANNER OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF DECEASED	
15. SIGNATURE OF FUNERAL HOME		16. SIGNATURE OF BURIAL PLACE	
17. SIGNATURE OF CEMETERY		18. SIGNATURE OF INTERVIEWER	
19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF INTERVIEWER	
21. SIGNATURE OF INTERVIEWER		22. SIGNATURE OF INTERVIEWER	
23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWER	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWER	
27. SIGNATURE OF INTERVIEWER		28. SIGNATURE OF INTERVIEWER	
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37. SIGNATURE OF INTERVIEWER		38. SIGNATURE OF INTERVIEWER	
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57. SIGNATURE OF INTERVIEWER		58. SIGNATURE OF INTERVIEWER	
59. SIGNATURE OF INTERVIEWER		60. SIGNATURE OF INTERVIEWER	
61. SIGNATURE OF INTERVIEWER		62. SIGNATURE OF INTERVIEWER	
63. SIGNATURE OF INTERVIEWER		64. SIGNATURE OF INTERVIEWER	
65. SIGNATURE OF INTERVIEWER		66. SIGNATURE OF INTERVIEWER	
67. SIGNATURE OF INTERVIEWER		68. SIGNATURE OF INTERVIEWER	
69. SIGNATURE OF INTERVIEWER		70. SIGNATURE OF INTERVIEWER	
71. SIGNATURE OF INTERVIEWER		72. SIGNATURE OF INTERVIEWER	
73. SIGNATURE OF INTERVIEWER		74. SIGNATURE OF INTERVIEWER	
75. SIGNATURE OF INTERVIEWER		76. SIGNATURE OF INTERVIEWER	
77. SIGNATURE OF INTERVIEWER		78. SIGNATURE OF INTERVIEWER	
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81. SIGNATURE OF INTERVIEWER		82. SIGNATURE OF INTERVIEWER	
83. SIGNATURE OF INTERVIEWER		84. SIGNATURE OF INTERVIEWER	
85. SIGNATURE OF INTERVIEWER		86. SIGNATURE OF INTERVIEWER	
87. SIGNATURE OF INTERVIEWER		88. SIGNATURE OF INTERVIEWER	
89. SIGNATURE OF INTERVIEWER		90. SIGNATURE OF INTERVIEWER	
91. SIGNATURE OF INTERVIEWER		92. SIGNATURE OF INTERVIEWER	
93. SIGNATURE OF INTERVIEWER		94. SIGNATURE OF INTERVIEWER	
95. SIGNATURE OF INTERVIEWER		96. SIGNATURE OF INTERVIEWER	
97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWER	
99. SIGNATURE OF INTERVIEWER		100. SIGNATURE OF INTERVIEWER	

ENCLOSURE

RECEIVED BY THE BUREAU OF VITAL RECORDS, MASSACHUSETTS DEPARTMENT OF HEALTH, BOSTON, MASS. APR 28 1955

BUREAU V. S.

APR 28 1955

RECEIVED

INSTRUCTIONS

1 The law requires that the death certificate be executed within **4 hours** after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3296

CERTIFICATE OF DEATH

03285

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>				TOWN <u>Annapolis</u>		10	
63 HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hospital</u>				STREET ADDRESS (If rural give location) <u>29 Murray Ave.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>WILLIAM A BASIL</u>				<u>APRIL 24, 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>May 25, 1885</u>	<u>69</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Carpenter</u>		<u>General Bldg.</u>		<u>Annapolis, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>John Basil</u>				14. MOTHER'S MAIDEN NAME <u>Anna Deale</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>—</u>		<u>219-03-6136</u>		<u>Mr. Charles F. Basil, Brother-Annapolis,</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Central Embolus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Vascular Disease</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M. <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>4/23</u> , 19 <u>55</u> , to <u>4/24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/24</u> , 19 <u>55</u> , and that death occurred at <u>6:50 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walter K. ...</u>				ADDRESS (Street, city, town, state) <u>Annapolis, Md</u>			
DATE SIGNED <u>4/26/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>April 26, 55</u>		<u>Cedar Bluff Cemetery</u>		<u>Annapolis, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>4-26-55</u>		<u>[Signature]</u>		<u>HOPPING FUNERAL HOME</u>		<u>ANNAPOLIS, MD</u>	
DATE							

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BUREAU V. S.

APR 27 1955

RECEIVED

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INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03286

3297

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ANNAPOLIS</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ANNAPOLIS Md.</u>		10	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CARVEL HALL HOTEL</u>				STREET ADDRESS (If rural give location) <u>CARVEL HALL HOTEL</u>			
3. NAME OF DECEASED (Type or Print) <u>LEVIN</u> (First) <u>HICKS</u> (Middle) <u>CAMPBELL</u> (Last)				4. DATE OF DEATH (Month) <u>4</u> (Day) <u>13</u> (Year) <u>1955</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>WIDOWED</u>	8. DATE OF BIRTH <u>11-7-1860</u>	9. AGE last birthday <u>94</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATTORNEY AT LAW</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LAW RET</u>		11. BIRTHPLACE (State or foreign country) <u>EASTON MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LEVIN HICKS CAMPBELL</u>				14. MOTHER'S MAIDEN NAME <u>MARY P. JONES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) _____ (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>LEVIN HICKS CAMPBELL JR (2)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>						<u>yes</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Deafness, Total</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/21</u> <u>1958</u> , to <u>4/13</u> <u>1955</u> , that I last saw the deceased alive on <u>4/8</u> <u>1955</u> , and that death occurred at <u>3 PM</u> <u>1955</u> , from the causes and on the date stated above. SIGNATURE <u>Frank M. Shively</u> M.D. <u>Annapolis</u> DATE SIGNED <u>4/13/55</u> 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>4-13-55</u> NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cent</u> LOCATION (City, town, or county) <u>Easton Md</u> 24. REC'D BY REGISTRAR <u>W. J. French</u> REGISTRAR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>Annapolis Md</u> DATE <u>April 14, 1955</u>							

CERTIFICATE OF DEATH

1. SEX AND AGE OF DECEASED

2. MARRIAGE

3. OCCUPATION

4. PLACE OF BIRTH

5. CAUSE OF DEATH

6. SIGNATURE OF PHYSICIAN

7. SIGNATURE OF WITNESSES

8. SIGNATURE OF REGISTRAR

BUREAU V. S.

APR 18 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03287

3298

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>		<u>3 days</u>		TOWN <u>Edgewater</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arunde General</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>DELLA A. DEAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 7 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>July 30 1871</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u>		11. BIRTHPLACE (State or foreign country) <u>Balt MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
163X IMMEDIATE CAUSE (A) <u>carcinoma lung</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerosis generalized</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 10, 1954</u> , to <u>April 7, 1955</u> ; that I last saw the deceased alive on <u>April 6, 1955</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Emily H. Wilson</u>				ADDRESS (Street, city, town, state) <u>Lattican, md</u>		DATE SIGNED <u>4-9-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/9/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mayo Memorial</u>		LOCATION (City, town, or county) (State) <u>Mayo, MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Ernest Thelma</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		ADDRESS <u>Galiville Ind</u>	
DATE <u>4/9/55</u>							

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03288

3299

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>10</u> TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place) <u>4</u> days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>		<u>10</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>57</u> <u>U.S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>206 Sycamore Court, USNavSta. Anna</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Joan Ann DOUGLAS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 27 1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cau</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>6-10-45</u>	9. AGE last birthday <u>9</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dep</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dependent/USN</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Biggs (Stepfather)</u>				14. MOTHER'S MAIDEN NAME <u>Garnet Guard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS <u>USNH Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
816X IMMEDIATE CAUSE (A) <u>CEREBRAL EDEMA 334.9</u>						<u>4</u> days	
ANTECEDENT CAUSE(S) DUE TO (B) <u>INTRACRANIAL HAEMORRHAGE FOLLOWING INJURY N855</u>						<u>4</u> days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>4-26-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Craniotomy- No significant findings</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Highway</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Ritchie Highway Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>April 23 55 1:30</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR? <u>Two car collision</u>			
22. I hereby certify that I attended the deceased from <u>4-23</u>, 19 <u>55</u>, to <u>4-27</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>4-27-55</u>, 19 <u>55</u>, and that death occurred at <u>4:05a</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>R.H. BROWN LCDR MC</u>				ADDRESS (Street, city, town, state) <u>U.S. Naval Hospital, Annapolis, Md.</u>			
DATE <u>4-28-55</u>				DATE SIGNED <u>27 April 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>4-29-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
24. REC'D BY REGISTRAR <u>4-28-55</u>		REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.H. Chambers</u>		ADDRESS <u>Eo Washington, D.C.</u>	

Wm. J. French B

MAY 2 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03289

3316

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY A. A.		MARYLAND		STATE Md.		COUNTY A. A.	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Ferndale		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Ferndale		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 204 Hollins Ferry Rd.				STREET ADDRESS 204 Hollins Ferry Rd.			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:			
(First) WILMER		(Middle) K.		(Last) DOWNS		(Month) (Day) (Year) April 4, 1955	
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: May 24, 1898	9. AGE last birthday: 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Driver		10B. KIND OF BUSINESS OR INDUSTRY: Costal Tank Line		11. BIRTHPLACE (State or foreign country): Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: William T. Downs				14. MOTHER'S MAIDEN NAME: Amanda V. Conner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: 215-12-3604		17. INFORMANT & ADDRESS: Ferndale, Md. Mrs. Laura K. Downs-204 Hollins Ferry Rd.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Carcinoma of the Lung - Primary						163X te month.	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from, 19....., to, 19....., that I last saw the deceased alive on April 1, 1955 , and that death occurred at 9 A.M. , from the causes and on the date stated above.							
SIGNATURE James S. Bellapier		ADDRESS M. D. 100 Central Ave. Glen Haven Md		DATE SIGNED April 4, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/7/55		NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park Cem.		LOCATION (City, town, or county) (State) A. A. Co., Md.	
DATE REC'D BY LOCAL REGISTRAR 4-6-55		REGISTRAR'S SIGNATURE A. W. Hedrick		24. FUNERAL DIRECTOR Wm. J. Tiekner & Sons - Balto Md		ADDRESS	

VOCAL RANGE BOUNDS

Female -



Male -

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3317 CERTIFICATE OF DEATH

03290
Reg. Dist. No. 24

1. PLACE OF DEATH: 203 1st Ave.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Anne Arundel	MARYLAND	STATE Same	COUNTY aa
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Glen Burnie	LENGTH OF STAY (in this place) Jan 1947	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Glen Burnie	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS 203 - 1st Ave.		STREET ADDRESS (If rural give location) 203 1st Ave.	1
3. NAME OF DECEASED: (First) Charles (Middle) Edmond (Last) Dryden		4. DATE OF DEATH: (Month) April (Day) 2 (Year) 1955	
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: Jan 6 - 1875
10a. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired: minister		10b. KIND OF BUSINESS OR INDUSTRY: minister	11. BIRTHPLACE (State or foreign country): Maryland
13. FATHER'S NAME: Lillian Dryden		14. MOTHER'S MAIDEN NAME: Lillian	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no		16. SOCIAL SECURITY No.: no	
17. INFORMANT & ADDRESS: Mrs. Edm. Dryden - 203 - 1st Ave Glen Burnie			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		48 hours
(a) Immediate cause		
(b) Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		10 years
(c) DUE TO		
11. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION: none		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19b. MAJOR FINDINGS OF OPERATION		

21. ACCIDENT SUICIDE HOMICIDE (Specify) no	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1945, to April 2, 1955, that I last saw the deceased alive on April 1, 1955, and that death occurred at 4 P. M., from the causes and on the date stated above.

SIGNATURE: James S. Bellingsha. (Degree or title) no

DATE SIGNED: April 2, 1955

ADDRESS: 108 Central Ave Glen Burnie

23. BURIAL, CREMATION, REMOVAL (Specify) Burial	DATE THEREOF April 5 - 1955	NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	LOCATION (City, town, or county) Glen Burnie, Maryland
DATE REC'D BY LOCAL REGISTRAR April 4 1955	REGISTRAR'S SIGNATURE J. P. De Alba	24. FUNERAL DIRECTOR R. V. Singleton	ADDRESS Glen Burnie, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 6 1955

RECEIVED

3318
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03291
 Reg. Dist. No. 20

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Anne Arundel</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN <u>Davidsonville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Davidsonville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Central Ave</u>		STREET ADDRESS (If rural, give location) <u>Central Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JOHN R DUCKETT</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 11, 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>August 31, 1918</u>
9. AGE last birthday: <u>36</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	
11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Frank S. Duckett</u>		14. MOTHER'S MAIDEN NAME: <u>EDNA Downey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u> <u>No</u>		16. SOCIAL SECURITY No.: <u>?</u>	
17. INFORMANT & ADDRESS: <u>Mr. Frank S. Duckett-Father- same as # 2</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
434.3 Immediate cause (a)..... <u>Heart Disease</u> DUE TO			
Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Natural</u>	21c. (City or town) (County) (State) <u>Davidsonville, Anne Arundel, Maryland</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>April 11, 55 A M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Natural causes</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>[Signature]</u> (ANNAPOLIS)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4-12-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>April 13, 55</u>	NAME OF CEMETERY OR CREMATORY <u>Davidsonville Methodist Cem.</u> LOCATION (City, town, or county) (State) <u>Davidsonville, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>April 12, 1955</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Hopping Funeral Home</u> ADDRESS <u>Annapolis, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL EXAMINATION REPORT

DATE

NAME

AGE

SEX

HEIGHT

WEIGHT

TEMP

PULSE

B.P.

RESPIR.

URINE

STOMACH

INTEST.

RECT.

GENIT.

SKIN

LABORATORY

NO.

PHYSICIAN

BUREAU V. S.

APR 19 1955

RECEIVED

DEVELOPMENT

XX

APR 11, 55

DEVELOPMENT

XX

APR 11, 55

DEVELOPMENT

DEVELOPMENT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 2

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Adams</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Adams</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Harwood</u>		LENGTH OF STAY (in this place) <u>5 months</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Harwood</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Jimmy</u>		(Middle) <u>Louis</u>		(Last) <u>Duval</u>		(Month) <u>4</u> (Day) <u>8</u> (Year) <u>1955</u>	
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>		8. DATE OF BIRTH: <u>1-7-55</u>	
9. AGE last birthday: <u>3 months</u>		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Prince George Hospital, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME: <u>Ashby Duval</u>			
14. MOTHER'S MAIDEN NAME: <u>Delores Griffith</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>			
16. SOCIAL SECURITY No.: <u>none</u>				17. INFORMANT & ADDRESS: <u>Dolores Griffith Harwood, Md</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
571.0 Immediate cause (a) <u>Pneumonia bronch-</u> DUE TO Antecedent cause(s) (b) <u>acute colitis with dehydration</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>✓</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Emory H. Wilson</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <u>4-8-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>4-11-55</u>		NAME OF CEMETERY OR CREMATORY <u>Chews Chapel</u>		LOCATION (City, town, or county) (State) <u>Owensville, Md</u>	
DATE REC'D BY LOCAL REG. <u>April 11, 1955</u>		REGISTRAR'S SIGNATURE <u>Elson Wood Williams</u>		24. FUNERAL DIRECTOR <u>William Reese Jr 108 Washington St</u>			
<u>2015204386</u> <u>ANNA POLIS, Md</u>							

03292

BUREAU V. B.

APR 15 1955

RECEIVED

3320

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Anne Arundel</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>aa.</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>X</i> TOWN <i>Orchard Beach</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Orchard Beach</i>	<i>X</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i> 7931 Main St.		STREET ADDRESS (If rural give location) 7931 Main St.	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>CATHERINE</i>	(Middle) <i>SARAH</i>	(Last) <i>FISHER</i>	(Month) <i>APRIL</i> (Day) <i>29</i> (Year) <i>1955</i>
5. SEX: <i>female</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>widowed</i>	8. DATE OF BIRTH: <i>June 21, 1882</i>
9a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>Housewife</i>		9b. KIND OF BUSINESS OR INDUSTRY: <i>at home</i>	9. AGE last birthday: <i>72</i> yrs. Months Days Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>at home</i>	11. BIRTHPLACE (State or foreign country): <i>Md.</i>
13. FATHER'S NAME: <i>Herod Engler</i>		14. MOTHER'S MAIDEN NAME: <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY No.: <i>no</i>	
17. INFORMANT & ADDRESS: <i>Orchard Beach</i> <i>Mrs. Millicent Smelser-7931 Main St.</i>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<i>420.1</i> Immediate cause (a) <i>Cerebral H. hemorrhage</i>		<i>6 days</i>
Antecedent causes (s) (b) <i>Arteriosclerotic Cardio Vascular Disease</i>		<i>5 years</i>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <i>Coronary Sclerosis</i>		<i>2 years</i>

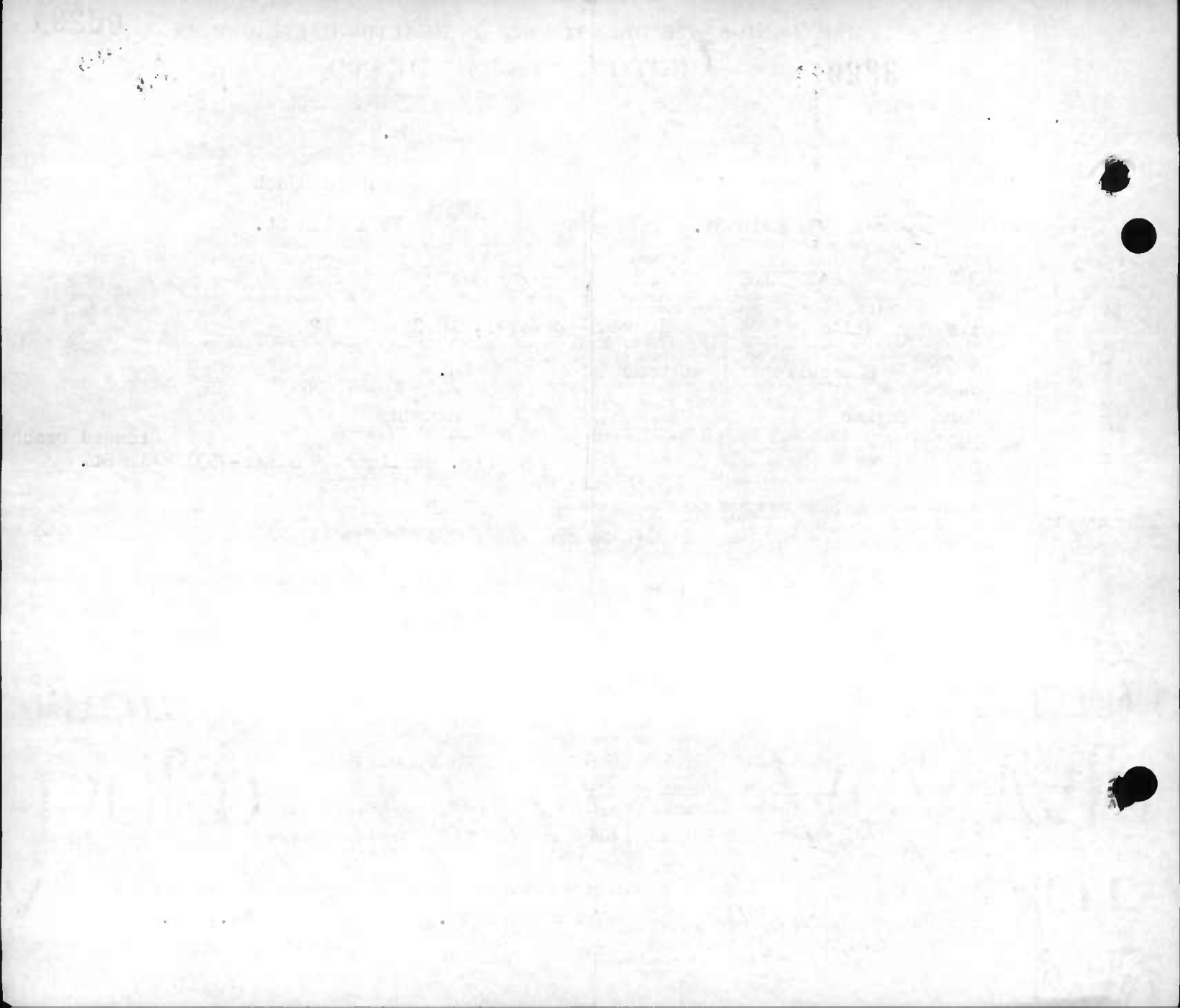
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <i>Dec 22</i> , 19 <i>54</i> , to <i>April 29</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>4/29</i> , 19 <i>55</i> , and that death occurred at <i>12:45 P.M.</i> from the causes and on the date stated above.		DATE SIGNED <i>4/29/55</i>
SIGNATURE <i>J. Brady Smith M.D.</i>		ADDRESS <i>Riverside Beach Md.</i>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<i>Burial</i>	<i>5/2/55</i>	<i>Loudon Park Cem.</i>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
<i>April 30 1955</i>	<i>R.W.</i>	<i>Wm. J. Pickens & Sons</i>
		ADDRESS <i>Balto 17 Md.</i>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3321

CERTIFICATE OF DEATH

03294

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X TOWN</u> <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>1yr 11mo 13days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>225 Myrtle Ave. Baltimore</u>		<u>3601-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>925 Myrtle Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>Mary</u> (First) <u>---</u> (Middle) <u>Fouts</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>April</u> <u>24</u> <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 2, 1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Gibson</u>				14. MOTHER'S MAIDEN NAME <u>Ella (maiden name unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown if any</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>4221</u> IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>						<u>4 days</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>Chronic myocarditis</u>						<u>Both known</u>	
DUE TO (C) <u>Generalized arteriosclerosis</u>						<u>to us since admission.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>---</u>							
19a. DATE OF OPERATION <u>---</u>		19b. MAJOR FINDINGS OF OPERATION <u>---</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>---</u>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>---</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>---</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>---</u>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>---</u>			
22. I hereby certify that I attended the deceased from <u>May 11</u> , 19 <u>53</u> , to <u>April 24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>April 24</u> , 19 <u>55</u> , and that death occurred at <u>11:40 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Maryland</u>		DATE SIGNED <u>April 24, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-27-55</u>		NAME OF CEMETERY OR CREMATORY <u>MT Auburn C.</u>		LOCATION (City, town, or county) (State) <u>Balt Md</u>	
24. REC'D BY REGISTRAR DATE <u>4/26/55</u>		REGISTRAR'S SIGNATURE <u>Latherine M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel W. Sullivan Jr</u> ADDRESS <u>Balt</u>			

CERTIFICATE OF DEATH

1951

REG. NO. 12

1. Name of deceased (Print or type)

MARYLAND

DATE OF DEATH

April 10, 1951

TIME OF DEATH

PRO. REVISED DEATH

EDUCATION

SEX

05

Age

Place of birth

Marital status

Occupation

Virginia

Married

Virginia

Unknown

Married

BUREAU V. S.

APR 26 1955

RECEIVED

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03295

3300

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis, Md.</u>				TOWN <u>Annapolis, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>129 Monticello Ave.</u>				STREET ADDRESS (If rural give location) <u>129 Monticello Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>WILLIAM N. FRENCH</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>4</u> <u>6</u> <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>6/11/1865</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pile Priving</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>William Henry French</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>William H. French #2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>420.0</u> <u>Arteriosclerotic Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>				<u>unknown</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-5</u>, 19<u>55</u>, to <u>4-6</u>, 19<u>55</u>, that I last saw the deceased alive on <u>4-6</u>, 19<u>55</u>, and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edward H. Bark</u>				DATE SIGNED <u>4-6-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		DATE THEREOF <u>4/8/55</u>		NAME OF CEMETERY OR CREMATORY <u>42 Societygate Burial Ground</u>		LOCATION (City, town, or county) (State) <u>Norfolk Va.</u>	
24. REC'D BY REGISTRAR DATE <u>April 11, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor and Sons</u>			
				ADDRESS <u>Annapolis, Md.</u>			

CERTIFICATE OF DEATH

23 0

APR 13 1955

1. DECEASED'S NAME (LAST, FIRST, MIDDLE)

2. SEX

3. DATE OF BIRTH

4. PLACE OF BIRTH

5. OCCUPATION

6. MARITAL STATUS

7. RACE

8. RELIGION

9. EDUCATION

10. SOCIAL SECURITY NUMBER

11. DATE OF DEATH

12. PLACE OF DEATH

13. CAUSE OF DEATH

14. MANNER OF DEATH

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF REGISTRAR

17. SIGNATURE OF WITNESSES

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF JUDGE

21. SIGNATURE OF CLERK

22. SIGNATURE OF SHERIFF

23. SIGNATURE OF DEPUTY SHERIFF

24. SIGNATURE OF JAILER

25. SIGNATURE OF WARDEN

26. SIGNATURE OF CHIEF OF POLICE

27. SIGNATURE OF DISTRICT ATTORNEY

28. SIGNATURE OF COUNTY CLERK

29. SIGNATURE OF COUNTY COMMISSIONER

30. SIGNATURE OF COUNTY SHERIFF

31. SIGNATURE OF COUNTY CLERK

BUREAU V. S.

APR 13 1955

RECEIVED

1

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03296

3301

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis, Maryland</u>		LENGTH OF STAY (in this place) <u>9 mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis, Maryland</u>		<u>10</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wherry Housing, USNS</u>				STREET ADDRESS (If rural give location) <u>42 Alder Rd., Wherry Housing,</u>			
<u>42 Alder, Annapolis, Maryland</u>				<u>U.S. Naval Station, Annapolis, Md.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>William</u>		(Middle) <u>David</u>		(Last) <u>GAFFNEY</u>			
				DATE OF DEATH <u>April</u> <u>4</u> <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>29 April 1953</u>	9. AGE last birthday <u>1</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>USNH, Charleston, S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William GAFFNEY</u>				14. MOTHER'S MAIDEN NAME <u>Vilola Lillian FOWLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or, unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Father, Same as #1</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
812X IMMEDIATE CAUSE (A) <u>LACERATION OF BRAIN</u>						INTERVAL BETWEEN ONSET AND DEATH <u>none</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Comminuted fracture of skull - frontal</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Accident</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Street</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Annapolis, Anne Arundel Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>April 4, 1955 10:45 AM</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21f. HOW DID INJURY OCCUR? <u>Run over by U.S. Mail Truck</u>			
22. I hereby certify that I attended the deceased from <u>11:10 AM</u> , 19 <u>4</u> , to <u>11:10 AM</u> , 19 <u>4</u> , that I last saw the deceased alive on <u>11:10 AM</u> , 19 <u>4</u> , and that death occurred at <u>11:10 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter T. Medic</u>				DATE SIGNED <u>U.S. Naval Station, Disp, Annapolis, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>				DATE THEREOF <u>4-5-1955</u>		LOCATION (City, town, or county) (State) <u>Methuen Mass.</u>	
24. REC'D BY REGISTRAR <u>April 5, 1955</u>		REGISTRAR'S SIGNATURE <u>John M. Taylor</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>			
DATE		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			

CERTIFICATE OF DEATH

3-11

1. THE DECEASED WAS A RESIDENT OF MARYLAND

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. PLACE OF DEATH

6. TIME OF DEATH

7. PLACE OF DEATH

8. TIME OF DEATH

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99. PLACE OF DEATH

100. TIME OF DEATH

BUREAU V. S.

APR 2 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03297

3322

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince Georges</u>	
CITY OR TOWN <u>Fort George G. Meade</u>		LENGTH OF STAY (in this place) <u>7 Months</u>		CITY OR TOWN <u>Laurel</u>		<u>16-41-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>620 9th Street</u>		✓	
3. NAME OF DECEASED (Type or Print) <u>LYNNETTE</u>				4. DATE OF DEATH (Month) <u>April</u> (Day) <u>29</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>April 28, 1955</u>	
9. AGE last birthday <u>0</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours Min.	
						<u>9 45</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Richard L. Griffin</u>				14. MOTHER'S MAIDEN NAME <u>Ernestine Hurt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT & ADDRESS <u>Mrs. Ernestine Griffin, 620 9th Street</u>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Prematurity</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 28, 1955</u> , to <u>April 29, 1955</u> , that I last saw the deceased alive on <u>April 29, 1955</u> , and that death occurred at <u>8:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Herbert L. Needleman</u>				DATE SIGNED			
HERBERT L. NEEDLEMAN, 1ST LT MC M.D. Fort George G. Meade, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2 May 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Post Cemetery</u>		LOCATION (City, town, or county) (State) <u>Fort George G. Meade, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>A. J. Gombosh</u>		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>29 April 1955</u>		A. J. GOMBOSH, CAPT. MSC		CHAPLAIN THEODORE OWENS, MAJOR			

2045251261

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. NAME OF DECEASED

2. PLACE OF DEATH

MARYLAND

Johns Hopkins

DATE OF DEATH

1955

TIME OF DEATH

10:00 AM

AGE

70 years

SEX

Male

RACE

White

EDUCATION

High School

OCCUPATION

Physician

CAUSE OF DEATH

Heart Disease

MANNER OF DEATH

Natural

DATE OF BURIAL

1955

PLACE OF BURIAL

St. John's Cemetery

NAME OF FUNERAL HOME

St. John's Funeral Home

NAME OF PHYSICIAN

Dr. J. H. Smith

NAME OF ATTENDING NURSE

Miss M. J. Brown

NAME OF WITNESS

Mr. J. H. Smith

NAME OF REGISTRAR

Mr. J. H. Smith

NAME OF CLERK

Mr. J. H. Smith

NAME OF DECEASED

Johns Hopkins

DATE OF DEATH

1955

TIME OF DEATH

10:00 AM

AGE

70 years

SEX

Male

RACE

White

EDUCATION

High School

OCCUPATION

Physician

CAUSE OF DEATH

Heart Disease

MANNER OF DEATH

Natural

DATE OF BURIAL

1955

PLACE OF BURIAL

St. John's Cemetery

NAME OF FUNERAL HOME

St. John's Funeral Home

NAME OF PHYSICIAN

Dr. J. H. Smith

NAME OF ATTENDING NURSE

Miss M. J. Brown

NAME OF WITNESS

Mr. J. H. Smith

NAME OF REGISTRAR

Mr. J. H. Smith

NAME OF CLERK

Mr. J. H. Smith

NAME OF DECEASED

Johns Hopkins

DATE OF DEATH

1955

TIME OF DEATH

10:00 AM

AGE

70 years

SEX

Male

RACE

White

BUREAU V. S.

MAY 4 1955

RECEIVED

ENCLOSURE

ENCLOSURE

ENCLOSURE

CERTIFICATE OF DEATH

Reg. Dist. No. 24

3323

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Anne Arundel</i>	MARYLAND	STATE <i>MD</i>	COUNTY <i>AA</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Bluen Buewe</i>	LENGTH OF STAY (If this place) <i>8 years</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Bluen Buewe</i>	TOWN <i>Bluen Buewe</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>614 - N. Crain Highway</i>		STREET ADDRESS (If rural give location) <i>Bluen Buewe</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>Ernest</i>	(Middle) <i>William</i>	(Last) <i>Hall</i>	(Month) <i>April</i> (Day) <i>19</i> (Year) <i>1955</i>
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married</i>	8. DATE OF BIRTH: <i>2/18/82</i>
9a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <i>Retired sailor</i>		9b. AGE last birthday: <i>83</i> yrs. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <i>Retired sailor</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Retired sailor</i>	
11. BIRTHPLACE (State or foreign country): <i>Anne Arundel County, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>?</i>		14. MOTHER'S MAIDEN NAME: <i>Mary Riblett</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY No.: <i>218-57-656</i>	
17. INFORMANT & ADDRESS: <i>Mrs. Annie Hall (wife)</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
Immediate cause <i>443X</i>		<i>+7 years</i>	
(a) <i>Hypertensive Cardio-Vascular</i>			
DUE TO			
Antecedent causes (s) <i>diseases</i>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.			
DUE TO			
(c)			
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: <i>-</i>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <i>-</i>		PLACE (Home, farm, factory, street, office bldg., etc.)	
SUICIDE		HOMICIDE	
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>-</i>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>June</i> 1948, to <i>4/19</i> 1955, that I last saw the deceased alive on <i>4/19/55</i> , 19, and that death occurred at <i>12:10 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Ernest W. Paerber MD.</i>		DATE SIGNED <i>4/19/55</i>	
ADDRESS <i>Bluen Buewe, Md.</i>			
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>April 22-55</i>	
NAME OF CEMETERY OR CREMATORY <i>Bluen Buewe</i>		LOCATION (City, town, or county) <i>Bluen Buewe</i>	
DATE REC'D BY LOCAL REGISTRAR <i>April 21, 1955</i>		REGISTRAR'S SIGNATURE <i>L. J. DeAlto</i>	
24. FUNERAL DIRECTOR <i>Demard G. Funt</i>		ADDRESS <i>Bluen Buewe Md</i>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 25 1955

BUREAU V. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Item 18 Film 6181 5-10-55 ans

3302

03299

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWN</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR <u>TOWN</u>		<u>Annapolis, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>63 Anne Arundel Gen. Hosp.</u>				STREET ADDRESS (If rural, give location) <u>111 Cathedral St.</u>			
3. NAME OF DECEASED: (First) <u>KENNETH</u>		(Middle) <u>E</u>		(Last) <u>HAMMOCK</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 20, 1955</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>Feb. 2, 1954</u>	
9. AGE last birthday: <u>14 mos.</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>			
13. FATHER'S NAME: <u>Richard Hammock</u>				14. MOTHER'S MAIDEN NAME: <u>Farigene Oldham</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		(If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Mr. Richard Hammock, Father- same as # 2</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>525x</u> Immediate cause (a) <u>Interstitial pneumonia and interstitial myocarditis</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>R. Fisher</u>				M. D. CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. <u>4/22/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>		DATE THEREOF <u>April 23, 55</u>		NAME OF CEMETERY OR CREMATORY <u>to</u>		LOCATION (City, town, or county) (State) <u>Knoxville, Tennessee</u>	
DATE REC'D BY LOCAL REG. <u>April 23, 1955</u>		RECEIVED BY SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR ADDRESS <u>Ben L. Hopping and Son Annapolis, Md.</u>			

BUREAU V. S.

APR 27 1953

RECEIVED

APR 28 1953

FOR THE HONORABLE

CERTIFICATE OF DEATH

5852

1. FULL NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. RACE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. PLACE OF DEATH

10. DATE OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESS

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BUREAU V. 3.

MAY 4 1955

RECEIVED

28-55

MARYLAND STATE DEPARTMENT OF HEALTH

03301

3325

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERSReg. Dist. No. 24

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Kansas</u> COUNTY <u>Saline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Arundale, Glen Burnie</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR TOWN Salina</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1303 Sapunders Way</u>		STREET ADDRESS (If rural, give location) <u>802 Saneca Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Victor</u> (Middle) <u>Hugo</u> (Last) <u>Hanf</u>	4. DATE OF DEATH	(Month) <u>April</u> (Day) <u>7</u> (Year) <u>1955</u>
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>9/18/89</u>
9. AGE last birthday <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman (retired due to illness)</u>	11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Hugo James Hanf</u>	
14. MOTHER'S MAIDEN NAME <u>?</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>1914-5-6</u>	
16. SOCIAL SECURITY No. <u>125-03-0077</u>		17. INFORMANT <u>Victor Hugo Hanf (Son)</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) <u>Coronary Occlusion</u>		<u>sudden</u>
(b) <u>Thrombo-Angiitis-Obliterans</u>		<u>3 y.</u>
(c) <u>Amputation of left leg (mid-thigh)</u>		<u>6 m.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death. <u>Gangrene of right leg.</u>		<u>3 m.</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
SIGNATURE <u>Deputy Medical Examiner</u>		DATE SIGNED <u>4/8/55</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>4/11/55</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>
LOCATION (City, town, or county) (State) <u>Glen Balto, 25, Md</u>	24. FUNERAL DIRECTOR <u>Hopping & KIRKLEY, Glen Burnie, Md.</u>	
DATE REC'D BY LOCAL REG. <u>April 9, 1955</u>	REGISTRAR'S SIGNATURE <u>L. J. DeAlta</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

BUREAU V. S.

APR 13 1955

RECEIVED

3326

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>a. a.</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>a. a.</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Brooklyn Heights</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn Heights</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>104 Edgewale Rd.</i>		STREET ADDRESS (If rural give location) <i>104 Edgewale Rd.</i>	
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Albert J. Herring</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>4/16/55</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <i>Married</i>	8. DATE OF BIRTH: <i>3/15/1876</i>
9. AGE last birthday <i>79</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Self</i>	
11. BIRTHPLACE (State or foreign country): <i>Green Co. Va.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>Charles Herring</i>		14. MOTHER'S MAIDEN NAME: <i>Nancy</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S ADDRESS:			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
592X IMMEDIATE CAUSE (A) <i>Uremia</i>			<i>2 days</i>
ANTECEDENT CAUSE (S) DUE TO <i>Chronic Nephritis</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (B) <i>Chronic Nephritis</i>			
(C) <i>Arteriosclerotic Heart Disease</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Asthma</i>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>3-31</i> , 1955, to <i>April 16</i> , 1955, that I last saw the deceased alive on <i>4-16-55</i> , 1955, and that death occurred at <i>5:34 PM</i> , from the causes and on the date stated above.			
SIGNATURE <i>Lois Green</i>		DATE SIGNED <i>4/16/55</i>	
M. O. <i>2730 N. Chestnut</i>			
23. BURIAL—CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		DATE THEREOF <i>4/16/55</i>	
NAME OF CEMETERY OR CREMATORY <i>ELKTON</i>		LOCATION (City, town, or county) (State) <i>Va.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>April 16, 1955</i>		REGISTRAR'S SIGNATURE <i>R.W.</i>	
24. FUNERAL DIRECTOR <i>Wm Cook Inc.</i>		ADDRESS <i>1217 St. Paul st.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03303

3303

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH COUNTY Anne Arundel MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) Annapolis TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hospital				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Anne Arundel CITY (If outside corporate limits, write RURAL and give nearest town) Davidsonville TOWN STREET ADDRESS (If rural give location) Davidsonville Post Office			
3. NAME OF DECEASED (Type or Print) LOUISE (First) Hittle (Middle) (Last) 4. DATE OF DEATH April 8 19 55 (Month) (Day) (Year)				5. SEX Female 6. COLOR OR RACE White 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed 8. DATE OF BIRTH March 29, 1880 9. AGE last birthday 75 yrs. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Euesch				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Mr Quentin Hittle- Son- same as # 2			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 260x IMMEDIATE CAUSE (A) Cerebral hemorrhage ANTECEDENT CAUSE(S) DUE TO (B) hypertension, generalized arteriosclerosis DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Diabetes mellitus						INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 1, 1955 , to April 8, 1955 , that I last saw the deceased alive on April 8, 1955 , and that death occurred at 1 P. M, from the causes and on the date stated above.							
SIGNATURE Emily H. Wilson M.D.				ADDRESS (Street, city, town, state) Lothian, Md.		DATE SIGNED 4-8-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF April 12, 55		NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		LOCATION (City, town, or county) Annapolis, Maryland	
24. REC'D BY REGISTRAR April 12, 1955		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		ADDRESS Annapolis, Md.	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

Name of Deceased [Illegible]		Date of Death [Illegible]	
Sex [Illegible]		Race [Illegible]	
Age [Illegible]		Place of Birth [Illegible]	
Usual Residence [Illegible]		Cause of Death [Illegible]	
Date of Death [Illegible]		Time of Death [Illegible]	
Place of Death [Illegible]		Signature of Physician [Illegible]	
Signature of Registrar [Illegible]		Signature of Coroner [Illegible]	

RECEIVED
 APR 13 1955
 BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3304 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Items 18, 21, 22 Film 6100 4-15-55 ans				03304 Reg. Dist. No. 21	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY Anne Arundel		MARYLAND	STATE Maryland		COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Annapolis		LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Parole-Annapolis		
HOSPITAL OR INSTITUTION OR STREET ADDRESS College Creek		STREET ADDRESS (If rural, give location) 1			
3. NAME OF DECEASED: (First) (Middle) (Last) JAMES W. JOHNS, SR.			4. DATE OF DEATH (Month) (Day) (Year) April 3 1955		
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W	8. DATE OF BIRTH: 6-9-1869		9. AGE last birthday: 85 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Fireman		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: William Johns			14. MOTHER'S MAIDEN NAME: Sophia Smith		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY No.: ?	17. INFORMANT & ADDRESS: Lawrence Johns 184 Fayette Ave		
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					INTERVAL BETWEEN ONSET AND DEATH
929.8 Immediate cause (a) Drowning DUE TO					
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Bank of creek	21c. (City or town) Annapolis	(County) Anne Arundel	(State) Md.	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Found 4/3 10:45AM.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Found apparently drowned on bank of creek			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE Paul F. Merri		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> Apr. 4, 1955	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF 4-7-55	NAME OF CEMETERY OR CREMATORY Fowler	LOCATION (City, town, or county) (State) Best Gate, Md		
DATE REC'D BY LOCAL REG. 4-4-55	REGISTRAR'S SIGNATURE R. W. Hedrick	24. FUNERAL DIRECTOR William Roosevelt		ADDRESS 108 Washington Annapolis, Md	

10880

10880

THE UNITED STATES OF AMERICA
DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

TO THE SECRETARY OF THE INTERIOR
FROM THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT
SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing land management activities, possibly related to a specific area or project. Key words that are faintly visible include "land", "management", "survey", "report", and "recommendations".]

Very truly yours,
[Illegible Signature]

Director, Bureau of Land Management

Approved:
[Illegible Signature]

Special Agent in Charge

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3305

CERTIFICATE OF DEATH

03305

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ANNE ARUNDEL		STATE Maryland		COUNTY Anne Arundel			
CITY (If outside corporate limits, write RURAL and give nearest town) 10 TOWN ANNAPOLIS		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gambrills		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 63 ANNE ARUNDEL GENERAL HOSPITAL				STREET ADDRESS (If rural give location) Box 127 Annapolis Road			
3. NAME OF DECEASED (First) (Middle) (Last) NANCY JOHNSON				4. DATE OF DEATH (Month) (Day) (Year) April 23, 19 55			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Sep.	8. DATE OF BIRTH August 3, 1892	9. AGE last birthday 62 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Sutherland				14. MOTHER'S MAIDEN NAME Almeda Fuller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) none		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Mrs Mary Jane Johnson-Daughter-same as #2			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) coronary occlusion						INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
ANTECEDENT CAUSE(S) DUE TO (B) aretriosclerotic cardiovascular disease.						8 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4/22/55 , 19....., to 4/23/55 , 19....., that I last saw the deceased alive on 4/23/55 19....., and that death occurred at 2:33 AM , from the causes and on the date stated above.							
SIGNATURE <i>S. Bornsude</i> M.D.				ADDRESS (Street, city, town, state) Annapolis, Md.		DATE SIGNED 4/23/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL		DATE THEREOF 4-23-55		NAME OF CEMETERY OR CREMATORY to		LOCATION (City, town, or county) (State) BRISTOL, TENNESSEE	
24. REC'D BY REGISTRAR DATE 4-23-55		REGISTRAR'S SIGNATURE <i>J. O. Daniel</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Ben. Hopping Jr.</i>		ADDRESS ANNAPOLIS, MD	

CERTIFICATE OF DEATH

1955

1. Name of deceased

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Date of death

7. Time of death

8. Cause of death

9. Signature of physician

10. Signature of registrar

11. Signature of informant

12. Signature of medical examiner

13. Signature of coroner

14. Signature of funeral director

15. Signature of health officer

16. Signature of registrar

17. Signature of medical examiner

18. Signature of coroner

19. Signature of funeral director

20. Signature of health officer

21. Signature of registrar

22. Signature of medical examiner

23. Signature of coroner

24. Signature of funeral director

25. Signature of health officer

BUREAU V. S.

APR 27 1955

RECEIVED

to

RECEIVED

1. Name of deceased
2. Sex
3. Race
4. Date of birth
5. Place of birth
6. Date of death
7. Time of death
8. Cause of death
9. Signature of physician
10. Signature of registrar
11. Signature of informant
12. Signature of medical examiner
13. Signature of coroner
14. Signature of funeral director
15. Signature of health officer
16. Signature of registrar
17. Signature of medical examiner
18. Signature of coroner
19. Signature of funeral director
20. Signature of health officer
21. Signature of registrar
22. Signature of medical examiner
23. Signature of coroner
24. Signature of funeral director
25. Signature of health officer

3327

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

COUNTY

ANNE ARUNDEL

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN RIVIERA BEACH

LENGTH OF STAY (in this place)

7 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Main Road

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Maryland

COUNTY

A. A.

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN

Riviera Beach

STREET ADDRESS

Main Road

3. NAME OF DECEASED:

(First)

JOHN

(Middle)

EARL

(Last)

KEYSER

4. DATE OF DEATH:

(Month)

(Day)

(Year)

April 27 1935

5. SEX:

MALE

6. COLOR OR RACE:

WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

married

8. DATE OF BIRTH:

9/12/77

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

77 yrs.

Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:

Carpenter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Baltimore

Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

John E. Keyser

14. MOTHER'S MAIDEN NAME:

Barbara Gunther?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY No.:

216-03-7175

17. INFORMANT & ADDRESS:

Earl Keyser - Riviera Beach, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

Immediate cause

(a) Cerebral Hemorrhage

Interval Between Onset And Death

6 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Arteriosclerotic Cardio Vascular Disease

10 years

(c) Hypertensive Cardio - Vascular Disease

10 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1952, to April 27, 1955, that I last saw the deceased

alive on 4/26, 1955, and that death occurred at 9:20 A.M.; from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

J. Brady Smith M.D.

Riviera Beach, Md.

4/28/55

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4-29-55

J. H. Hedrick

J. H. Hedrick

5305 Harford

MARGIN RESERVED FOR BINDING

1927



WILLIAM BROWN

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03307

3306

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>10 Annapolis</u>				TOWN <u>Glen Burnie</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>63 Anne Arundel General Hospital</u>				<u>Old Annapolis Rd. (P.O. Box 24)</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MORSON</u> (Middle) <u>LEISNER</u> (Last)				(Month) (Day) (Year)			
				<u>4.23.1955</u> 19			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>4-22-1955</u>	<u>42</u> yrs.	Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>		<u>None</u>		<u>Annapolis, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Marvin Meadows</u>				<u>Thelma Leisner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Marvin Meadows - same as # 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
758.1 IMMEDIATE CAUSE (A) <u>Achondroplastic Dwarf F</u>				INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 22, 1955</u> , to <u>April 23, 1955</u> , that I last saw the deceased alive on <u>April 23, 1955</u> , and that death occurred at <u>3:55 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edward G. Bennett</u>		M.D. <u>Glen Burnie Md</u>		DATE SIGNED <u>4-23-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-25-55</u>		<u>Glen Haven Cemetery</u>		<u>Glen Burnie, Maryland</u>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		HOPPING FUNERAL HOME		ANNAPOLIS, MD.	
DATE <u>4-25-55</u>							

2045203415

CERTIFICATE OF DEATH

37-18

1. FULL REGISTERED NAME OF DECEASED

JOHN J. JONES

2. SEX

MALE

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF DECEASED

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF PHYSICIAN

18. SIGNATURE OF CLERK

19. SIGNATURE OF REGISTRAR

20. SIGNATURE OF DECEASED

21. SIGNATURE OF WITNESSES

22. SIGNATURE OF PHYSICIAN

23. SIGNATURE OF CLERK

24. SIGNATURE OF REGISTRAR

25. SIGNATURE OF DECEASED

26. SIGNATURE OF WITNESSES

27. SIGNATURE OF PHYSICIAN

28. SIGNATURE OF CLERK

29. SIGNATURE OF REGISTRAR

BUREAU V. S.

APR 27 1955

RECEIVED

RECEIVED

RECEIVED

1-20-55

1

INSTRUCTIONS

1 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03308

3328

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Pennsylvania		COUNTY Northampton	
CITY OR TOWN Fort George G. Meade		LENGTH OF STAY (in this place) 25 Days		CITY OR TOWN Easton		75 X - 3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Army Hospital				STREET ADDRESS (if rural give location) 43 N. Sitgreaves			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) JAMES		(Middle) M.		(Last) LOVETT		(Month) April (Day) 18 (Year) 19 55	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 8 January 1932	9. AGE last birthday 23 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U. S. Army		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Howard W. Lovett				14. MOTHER'S MAIDEN NAME Eileen Shanahan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO. 28 December 1954		17. INFORMANT & ADDRESS None Mother: same as #2			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
590X IMMEDIATE CAUSE (A) Cardiac Failure				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) Uremia				Approx 25 days			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Acute Glomerulo-nephritis							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 25 March 19 55		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 25 March 19 55 , to 18 April 19 55 , that I last saw the deceased alive on 18 April 19 55 , and that death occurred at 0130 M, from the causes and on the date stated above.							
SIGNATURE Robert J. Dean				DATE SIGNED 18 April 19 55			
ROBERT J. DEAN, MAJOR, MC				M.D. U. S. Army Hospital, Ft. G. G. Meade, Md, 18 Apr 55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Unknown		NAME OF CEMETERY OR CREMATORY Gethsemane Cemetery		LOCATION (City, town, or county) (State) Easton, Pennsylvania	
24. REC'D BY REGISTRAR 18 April 1955		REGISTRAR'S SIGNATURE A. J. G. BUSH, CAPT. MSC		25. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.		ADDRESS Baltimore, Maryland	

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RECEIVED

1

INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03309

3329

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Prince George's	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Crownsville		1 1/2 years		TOWN Chapel Oaks		16X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital				STREET ADDRESS (If rural give location) Unknown			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Harrison (Middle) (Last) Maddox				(Month) 4 (Day) 10 (Year) 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	Negro	Separated	Unknown	66? yrs.	Months — Days —	Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Unknown		Unknown		Georgia		U. S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Hodge Maddox				Maggie Maddox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		Unk.		Hospital Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
33/X IMMEDIATE CAUSE (A) Cerebro-vascular accident						1 day	
ANTECEDENT CAUSE(S) DUE TO Hypertension						2-3 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO Generalized arteriosclerosis							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile Psychosis						2-3 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1/5 , 19 55 , to 4/10 , 19 55 , that I last saw the deceased alive on 4/10 , 19 55 , and that death occurred at 1:25 p.m. , from the causes and on the date stated above.							
SIGNATURE H. Edgar Heard				ADDRESS (Street, city, town, state) Crownsville, Md.		DATE SIGNED 4/10/55	
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		4-13-55		Ch. M. R.		Balto. Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 4-13-55		H. M. Sojoe		F. H. Hensley		575 W. Bridge St.	

CERTIFICATE OF DEATH

1939

Reg. Dist. No.

1. NAME AND RESIDENCE (HOMER OR RESIDENT)

NAME: John J. Hays
 RESIDENCE: 1000 E. Pratt St.
 CITY: Baltimore
 STATE: Md.
 ZIP: 21201

2. PLACE OF DEATH

1. Home

3. DATE AND TIME OF DEATH

DATE: April 15, 1939
 TIME: 10:30 A.M.

4. CAUSE OF DEATH (as certified by physician)

1. Myocardial Infarction

2. Coronary Thrombosis

5. SEX AND AGE

SEX: Male
 AGE: 45

6. OCCUPATION

Engineer

7. MARITAL STATUS

Married

8. RACE

White

9. MEDICAL HISTORY

None

10. PRESENT ILLNESS

Myocardial Infarction

11. SIGNATURE OF PHYSICIAN

John J. Hays

12. SIGNATURE OF REGISTRAR

John J. Hays

BUREAU V. S.

APR 15 1939

RECEIVED

INSTRUCTIONS TO REGISTRARS

1. The death certificate is a legal document and must be filled out correctly.

2. The death certificate is a legal document and must be filled out correctly.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03340

3330

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>AA-</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA-</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Leathman</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>208 W. Hawthorne Rd.</u>				STREET ADDRESS (If rural give location) <u>208 W. Hawthorne Rd.</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
<u>Gilbert Lewis Morris Maris</u>				<u>April 6 1955</u>			
5. SEX: <u>Sm</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Nov. 8, 1880</u>	9. AGE last birthday: <u>74</u> yrs.	IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Brokenworks, 12 R. (Retired)</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Wm D. Maris</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Francis Fischer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) <u>705-05-6080</u>		17. INFORMANT & ADDRESS: <u>Emma Maris (Wife)</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>526X</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Cardio-Vascular Disease</u>						<u>14 yr -</u>	
DUE TO							
(B) <u>Chronic Bronchitis</u>						<u>30 yr -</u>	
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Enlargement of Prostate</u>						<u>6 mo -</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug</u> , 19 <u>54</u> , to <u>4/6/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/6/55</u> , 19 <u>55</u> , and that death occurred at <u>10 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Chas. L. Ball</u>		M. D. <u>Linchman</u>		DATE SIGNED <u>4/6/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>April 11, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Gravel Hill</u>		LOCATION (City, town, or county) (State) <u>Balt</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-7-55</u>		REGISTRAR'S SIGNATURE <u>and Hedrick</u>		FUNERAL DIRECTOR <u>G. Ballard Ellison</u>		ADDRESS <u>1400 S. Charles St</u>	

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 72.51

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3331

03311

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A. A.</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>AA</u>	
CITY OR TOWN <u>RIVA</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>RIVA</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>SAMUEL</u> <u>MC GOWANS</u>				<u>4</u> <u>28</u> <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>Colored</u>	<u>MARRIED</u>	<u>12-24-1906</u>	<u>48</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Truck Driver</u>				<u>West River, Md</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George Mc GOWANS</u>				<u>Francis Downs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>YES</u> <u>W. W. W. A. T. E.</u>		<u>212-12-2991</u>		<u>MARY MC GOWANS RIVA, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
151X IMMEDIATE CAUSE (A) <u>Carcinoma of the stomach</u>						INTERVAL BETWEEN ONSET AND DEATH <u>approx 8 mos.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-2</u> , 19 <u>54</u> , to <u>4-28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4-28</u> , 19 <u>55</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. Allen</u> M.D.				ADDRESS (Street, city, town, state) <u>10 Carroll St</u>		DATE SIGNED <u>4-28-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>5-2-55</u>		<u>ANNA POLIS NATIONAL</u>		<u>ANNA POLIS Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>May 2, 1955</u>		<u>Edward Collinson</u>		<u>William Reese II</u>		<u>108 W. Washington St</u>	
				<u>ANNAPOLIS, Md</u>			

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3397

CERTIFICATE OF DEATH

03312

Reg. Dist. No. 21

Item 9, Film G181 5-19-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
10 TOWN <u>Annapolis, Md</u>		DOA		TOWN <u>Annapolis, Md.</u>		10	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>311 Monteray Ave.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Hugh B McLean</u>				<u>April 21 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>Cau</u>	<u>M</u>	<u>21 Dec. 1901</u>	<u>53 1/2</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>USN</u>		<u>Retired</u>		<u>Orange, Texas</u>		<u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>1924 -</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
						<u>USNH Records</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u> 420.1						INTERVAL BETWEEN ONSET AND DEATH <u>Immed.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>DOA 4-21</u> , 19 <u>55</u> , to <u>4-21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>DOA</u> , 19 <u>55</u> , and that death occurred at <u>1830</u> M., from the causes and on the date stated above.							
SIGNATURE <u>H.R. Moxon</u> LCDR MC USN				ADDRESS (Street, city, town, state) <u>U.S. Naval Hospital</u> DATE SIGNED <u>22 April 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr 26 55</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
24. REC'D BY REGISTRAR <u>John M. Saylor</u>		REGISTERING SIGNATURE <u>John M. Saylor</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor</u>		ADDRESS <u>Annapolis Md.</u>	
DATE <u>April 25, 1955</u>							

CERTIFICATE OF DEATH

3887

MD. DEPT. HEALTH

1. LOCAL HEALTH OFFICE OF JURISDICTION

2. PLACE OF DEATH

MARYLAND

STATE OF MARYLAND

CITY OF BALTIMORE

WILLIAM J. BROWN

WILLIAM J. BROWN

WHITE

WHITE

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INSTRUCTIONS

INSTRUCTIONS

BUREAU V. S.

APR 27 1955

RECEIVED

Life at 25 Washington Veterans Building

APR 27 1955

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03313

3332

CERTIFICATE OF DEATH

Reg. Dist. No. 18

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Crownsville</u>		5 yrs. 2 mos.		CITY OR TOWN <u>Baltimore City</u>		3V01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
10 <u>Crownsville State Hospital</u>				Undetermined			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Howard</u> <u>McRae</u>				<u>4</u> <u>21</u> <u>19</u> <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Negro</u>	<u>Single</u>	<u>2/16/95</u>	<u>60</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Cook</u>		<u>Unknown</u>		<u>South Carolina</u>		<u>U. S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George McRae</u>				<u>Rhodea Manning</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>Unk.</u>		<u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>1 day</u>	
450.0 IMMEDIATE CAUSE (A) <u>Broncho-pneumonia, bilateral</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/5</u> , 19 <u>55</u> , to <u>4/21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/21</u> , 19 <u>55</u> , and the death occurred at <u>7:00 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Edgar Reissmann</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>4/22/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>4/28/55</u>		<u>University Medical School</u>		<u>Balt.-city</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>4/26/55</u>		<u>R. M. Loyce</u>		<u>Mr. Henry</u>		<u>578 W. Biddle St</u>	

BUREAU V. S.

MAY - 2 -

RECEIVED

03314

MARYLAND STATE DEPARTMENT OF HEALTH

3333

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 27

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Jessup</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Annapolis Rd.</u>		STREET ADDRESS (If rural, give location) <u>Jessup</u>	
3. NAME OF DECEASED (Type or Print) <u>Carl Lewis</u> (First) <u>Nicholson</u> (Middle) (Last)		4. DATE OF DEATH <u>April 11</u> 19 <u>68</u> (Month) (Day) (Year)	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>9/23/54</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>13</u> yrs. If under 1 year Months <u>6</u> Days <u>12</u> Hours <u>0</u> Mins. <u>0</u>
11. FATHER'S NAME <u>Messle Nicholson</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. MOTHER'S MAIDEN NAME <u>James Beene Neal</u>		14. BIRTHPLACE (State or foreign country) <u>Severn Md</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Messle Nicholson</u> <u>Jessup</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

527.2

Immediate cause

(a) Acute Pulmonary Infection

INTERVAL BETWEEN ONSET AND DEATH

+ 12 hrs.

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

CAUSE OF DEATH.

TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Justine H. Paubert MDDeputy Medical ExaminerBlenn Beech, Md.4/11/68

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REC.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

April 13-68Lara HaskupRidgely, Md.Samuel mal

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 9 1951

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

03315

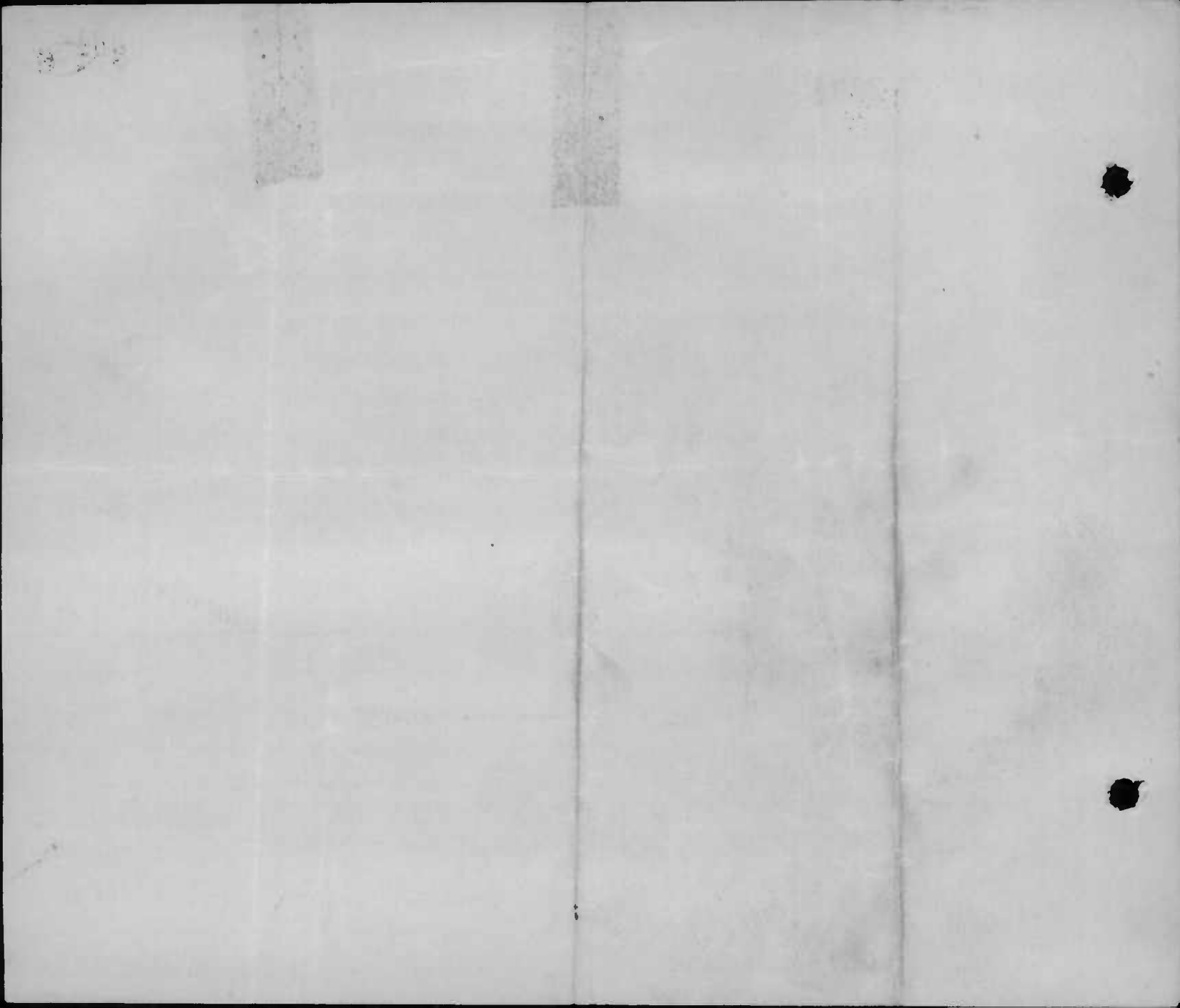
3334

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE _____ COUNTY _____			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Green Haven</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Laurel</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Catharine and T St.</u>				STREET ADDRESS (If rural, give location) <u>Laurel</u>			
3. NAME OF DECEASED (Type or Print) <u>Thomas</u>		(First) _____ (Middle) _____ (Last) <u>Novak</u>		4. DATE OF DEATH <u>April 5 - 1955</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1/23/97</u>	9. AGE last birthday <u>58</u> yrs.		If under 1 year: Months _____ Days _____ If under 24 hrs: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired as a chauffeur</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Thomas Novak</u>				14. MOTHER'S MAIDEN NAME <u>Marie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>212-32-9877</u>		17. INFORMANT AND ADDRESS <u>Mrs. Alma Novak (wife)</u>		
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>Coronary Occlusion</u> Antecedent cause(s) (b) _____ Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION _____				19b. MAJOR FINDINGS OF OPERATION _____			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY _____				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR? _____	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>							
SIGNATURE <u>Ernestine A. Pauley</u>				(Degree or title) <u>Registered Medical Examiner</u>		ADDRESS <u>Green Haven, Md.</u> DATE SIGNED <u>4/5/55</u>	
23. BURIAL, CREMATION OR REMOVAL (Specify) <u>Buried</u>		DATE THEREOF <u>4-9-55</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Hill</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
DATE REC'D BY LOCAL REG. <u>4-7-55</u>		REGISTRAR'S SIGNATURE _____		24. FUNERAL DIRECTOR <u>Frank Cuch + Son</u>		ADDRESS <u>900 N. Chester St</u>	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A155 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03316

3308

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>ANNAPOLIS</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A. A. GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>200 SEVERN AVE.</u>			
3. NAME OF DECEASED (Type or Print) <u>NELLIE P. PARKS</u>				4. DATE OF DEATH <u>4-6-1955</u>			
(First)		(Middle)		(Last)			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>9-11-1885</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if raised) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARY MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WESLEY GARDNER</u>				14. MOTHER'S MAIDEN NAME <u>MARY E JACKSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>WILLIAM E PARKS (2)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>cerebral hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>with left hemiplegia</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>gen. arteriosclerosis</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-5</u>, 19<u>55</u>, to <u>4-5</u>, 19<u>55</u>, that I last saw the deceased alive on <u>4-5</u>, 19<u>55</u>, and that death occurred at <u>5:54</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>South Poller</u>		DATE THEREOF <u>4-8-55</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>		LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>							
24. REC'D BY REGISTRAR <u>April 11, 1955</u>		REGISTRAR'S SIGNATURE <u>J. J. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. ...</u>		ADDRESS <u>Annapolis Md</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. PLACE OF BIRTH

8. OCCUPATION

9. SEX

10. AGE

11. MARITAL STATUS

12. EDUCATION

13. RELIGION

14. RACE

15. DATE OF BIRTH

16. TIME OF BIRTH

17. PLACE OF BIRTH

18. OCCUPATION

19. SEX

20. AGE

21. MARITAL STATUS

22. EDUCATION

23. RELIGION

24. RACE

25. DATE OF BIRTH

26. TIME OF BIRTH

27. PLACE OF BIRTH

28. OCCUPATION

29. SEX

30. AGE

31. MARITAL STATUS

32. EDUCATION

33. RELIGION

34. RACE

35. DATE OF BIRTH

36. TIME OF BIRTH

37. PLACE OF BIRTH

38. OCCUPATION

39. SEX

40. AGE

41. MARITAL STATUS

42. EDUCATION

43. RELIGION

44. RACE

BUREAU V. S.

APR 13 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3335

CERTIFICATE OF DEATH

03317

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>M.D.</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Crystal Beach.</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS <u>MANHATTAN Beach. 1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Fredrick E. Pendlebury</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 24 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>8 Jan 1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steward</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ship</u>		11. BIRTHPLACE (State or foreign country) <u>Framingham MASS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward Pendlebury</u>				14. MOTHER'S MAIDEN NAME <u>Madeline Kellerman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>1917-</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>wife - Manhattan Beach</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Respiratory & Cardiac failure</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial Infarction</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized Arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1917</u> to <u>1955</u> , that I last saw the deceased alive on <u>April 23, 1955</u> , and that death occurred at <u>07:45</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Robert R. Hahn</u>		M.D.		ADDRESS (Street, city, town, state) <u>Severna Park Md.</u>		DATE SIGNED <u>24 April</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 27, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Balto-Nat'l Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR <u>April 29, 1955</u>		REGISTRAR'S SIGNATURE <u>L. W. Alba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. K. Sington</u>		ADDRESS <u>Allen B. Bunn, Md.</u>	

CERTIFICATE OF DEATH

3508

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. PLACE OF BIRTH

9. DATE OF BIRTH

10. SEX OF BIRTH

11. COLOR OF BIRTH

12. RELIGION

13. OCCUPATION

14. EDUCATION

15. MARRIAGE

16. SERVICE

17. INTERVIEW

18. SIGNATURE

19. DATE

20. PLACE

21. COUNTY

22. STATE

*on
near
Missouri*

BUREAU V. 3

MAY 2 1955

RECEIVED

Part 1

RECEIVED

10 VILLAGE STREET, BOSTON, MASS. 02108

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03318

3336

CERTIFICATE OF DEATH

Item 9, Film G181, 5/12/55 fcy

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL or give nearest town) <u>X ST MARGARETS</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ST MARGARETS</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>60</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>MINNIE E. PUSCHERT</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>4-29-1955</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>5-3-1881</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>ERNESTINE THOBER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>SARA STREIT (2)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
162X IMMEDIATE CAUSE (A) <u>Bronchogenic carcinoma c gen. metastasis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B)							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>gen. arteriosclerosis</u>							
19a. DATE OF OPERATION <u>4/20/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>metastatic Ca (biopsy of nodes od neck lt.)</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 13, 1950</u> , to <u>4/29/1955</u> , that I last saw the deceased alive on <u>4/28/1955</u> , and that death occurred at <u>8:0 A</u> , from the causes and on the date stated above.							
SIGNATURE <u>S. Bonnum</u>		M. D. <u>Annapolis, Md.</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>4/29/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>4-29-55</u>		NAME OF CEMETERY OR CREMATORY <u>Tobeka Kansas</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>5-3-1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Saylor</u>			
DATE				ADDRESS <u>Annapolis Md.</u>			

CERTIFICATE OF DEATH

32528

IN TESTAMENTS OF THE DEPARTMENT OF HEALTH

NAME AND

RESIDENCE

DATE

PLACE

TIME

CAUSE

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BUREAU V. B.

MAY 4 1955

RECEIVED

RECEIVED

3337

CERTIFICATE OF DEATH

Reg. Dist. No. 28

Items 13, 14 Film 181 5-3-55 et

1. PLACE OF DEATH COUNTY <u>AA</u> <u>Armstrong</u> <u>State</u> <u>Hospital</u> <u>MARYLAND</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crownsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>State Hospital Crownsville</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Somerset</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crisfield</u> STREET ADDRESS (If rural give location) <u>19-39-2</u>	
3. NAME OF DECEASED (Type or Print) <u>William T. ROACH</u>		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>24</u> (Year) <u>55</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>African</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>?</u>	8. DATE OF BIRTH <u>?</u>
9. AGE last birthday <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>?</u> Days <u>?</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ed</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>Emm</u>	
17. INFORMANT'S ADDRESS <u>Emm FERGUSON, 915 Edward, The Per</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 9047 IMMEDIATE CAUSE (A) <u>Bacterial pneumonia</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Fracture of R. femur</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>generalized arteriosclerosis</u>		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>1 month</u> <u>3 years</u> <u>2 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>senile psychosis</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY, etc.) <u>State Hospital</u>	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>State Hospital</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>7-25-55</u> M. <u>?</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>Fall</u>			
22. I hereby certify that I attended the deceased from <u>4/17</u> , 19 <u>55</u> , to <u>4/24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/24</u> , 19 <u>55</u> , and that death occurred at <u>1:00</u> P.M. from the causes and on the date stated above.			
SIGNATURE <u>Walter Heard Korman</u> M.D. <u>State Hospital</u> DATE SIGNED <u>4/24/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. NAME OF CEMETERY OR CREMATORY	
DATE THEREOF <u>4/27/55</u>		LOCATION (City, town, or county) (State) <u>Crisfield R.F.D. #1, Md.</u>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REGISTRAR'S SIGNATURE <u>R. M. Royce</u>		ADDRESS <u>Bradshaw & Sons Crisfield, Md.</u>	
DATE <u>4/25/55</u>			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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فردوسی در زندان
بدرگاه اقبال

قند و شکر و روغن و غیره

... ۱۹۶۵ ...

در جلسه دوم

— ۱۴۴۴

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[Faint handwritten text at the bottom of the page, possibly "KUNSTGEMÄLDE"]

Small papillae
generalized on the
surface of the heart
Punctate papillae

جولائی ۱۹۵۷ء کو

BUREAU V. S.

1955

46

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RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3338

MARYLAND STATE DEPARTMENT OF HEALTH

03320

CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 24

Item 9. Film 181 5-6-55 et

1. PLACE OF DEATH - COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Arundel Beach		LENGTH OF STAY 5 minutes		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore		3Y01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Magothy River				STREET ADDRESS Lee Hotel, Rutaw Place			
3. NAME OF DECEASED (First) (Middle) (Last) Marion Rustin Roberts		4. DATE OF DEATH April 26- 1955		5. SEX Male		6. COLOR OR RACE White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH 5/3/03		9. AGE last birthday 52 51 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Roberts		14. MOTHER'S MAIDEN NAME Estella Laib		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) Yes 11 War.		16. SOCIAL SECURITY NO. 362-09-4146	
17. INFORMANT AND ADDRESS Mr. George W. Roberts, Linthicum.		18. MEDICAL CERTIFICATION		19. DATE OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 850X Immediate cause (a) Accidental Drowning		Interval Between Onset and Death Sudden		Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) Magothy River		(CITY OR TOWN) Arundel Beach,		(COUNTY) A.A. Md.	
TIME (Month) (Day) (Year) (Hour) 4/26/55 5.25 P.M.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? Boat capsized and he fell in the		(water.)	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .		SIGNATURE Medical Examiner, Glen Burnie Md.		ADDRESS 4/26/55		DATE SIGNED	
23. BURIAL, CREMATION, REINTERMENT, (Specify) Burial		DATE THEREOF 4-29-1955		NAME OF CEMETERY OR CREMATORY Baltimore National Comet		LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE RECD BY LOCAL REG. April 28, 1955		REGISTRAR'S SIGNATURE L. J. DeAlba		24. FUNERAL DIRECTOR Hopping and Kirkley Funeral Home		ADDRESS Glen Burnie, Md.	

BUREAU V. 3

MAY 2 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

3339

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

03321

Reg. Dist. No. 22

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A.A. Co.</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>A.A. Co.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>ODENTON</u>				TOWN <u>ODENTON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>MINERVA A. ROSS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>4 9 1955</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>3-5-1889</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HERBERT PARKER</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH PARKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT & ADDRESS <u>BENJAMIN A. JOHNSON ODETON, MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
171X IMMEDIATE CAUSE (A) <u>Generalized Carcinomatosis</u>		DUE TO				<u>3 Years</u>	
ANTECEDENT CAUSE(S) (B) <u>Carcinoma of Cervix Uteri</u>		DUE TO				<u>3 Years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)		DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct</u> , 19 <u>46</u> , to <u>April 19</u> , 19 <u>55</u> that I last saw the deceased alive on <u>April 7</u> , 19 <u>55</u> and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edmond J. Bennett</u>				ADDRESS (Street, city, town, state) <u>Cambria, Md</u>		DATE SIGNED <u>4-9-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-13-55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt Tabor</u>		LOCATION (City, town, or county) (State) <u>Chesterfield Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Edward Ross</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William R. Rountree</u>		ADDRESS <u>108 Washington St Annapolis, Md</u>	
DATE <u>Apr 15</u>							

CERTIFICATE OF DEATH

3238

1. REGISTRATION DISTRICT OR ADDRESS

MARYLAND

2. PLACE OF DEATH

HOME

STREET

CITY

STATE

ZIP

COUNTY

DATE

TIME

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3309

CERTIFICATE OF DEATH

03322

21

Item 9. FilmGl81 5-9-55 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place) <u>16 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>USNH</u>				STREET ADDRESS (If rural give location) <u>St Joseph's Home for Aged</u> <u>132 S Patterson Park Avenue</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Stanley</u> (n) <u>SAWULA</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 28</u> <u>19 55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>5-8-81</u>	9. AGE last birthday <u>74</u> <u>73</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>USN Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
491X IMMEDIATE CAUSE (A) <u>Bronchial Pneumonia #491</u>						<u>1-2 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atrophy of cerebral cortex, senile #794</u>						<u>Undetermined</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-12</u> <u>19 55</u> , to <u>4-28</u> <u>19 55</u> , that I last saw the deceased alive on <u>4-28</u> <u>19 55</u> , and that death occurred at <u>8:30a</u> <u>M</u> , from the causes and on the date stated above. SIGNATURE <u>I. A. Almenoff</u> ADDRESS (Street, city, town, state) <u>U.S. Naval Hospital, Annapolis, Md.</u> DATE SIGNED <u>4-28-55</u> <u>MC USN</u> M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 30, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>		LOCATION (City, town, or county) (State) <u>Wilmington Delaware</u>	
24. REC'D BY REGISTRAR <u>May 2, 1955</u>		REGISTRAR'S SIGNATURE <u>Wm. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas W. Singleton</u>		ADDRESS <u>New Bernice</u>	

BUREAU V. S.

MAY 4 1955

RECEIVED

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03323
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR		TOWN <u>Annapolis</u>	
10 TOWN <u>Annapolis</u>				STREET ADDRESS (If rural, give location)		2 <u>Annapolis Street</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>DOA Anne Arundel General</u>							
3. NAME OF DECEASED: (First) <u>GEORGE</u>		(Middle) <u>F</u>		(Last) <u>SCHNEEBERG</u>		4. DATE OF DEATH <u>APRIL 24</u> 19 <u>55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>October 5, 1900</u>	9. AGE last birthday: <u>54</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Auto Garage</u>		11. BIRTHPLACE (State or foreign country): <u>New York City, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Henry A. Schneeberg</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Mulligan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		(If Yes, give war or dates of service) <u>1919 to 1937 and WW II</u>		16. SOCIAL SECURITY No.: <u>215-18-0635</u>		17. INFORMANT & ADDRESS: <u>725 4th Ave. Harry Schneeberg-Brother- Brooklyn, N.Y.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <u>Fracture Skull</u>	DUE TO	
Antecedent cause(s) (b) <u>Compound Fracture both lower extremities</u>	DUE TO	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Street</u>	21c. (City or town) (County) (State) <u>Annapolis, Anne Arundel, Maryland</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>April 24, 1955 PM</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Struck by Car near College Creek Bridge</u>

22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .	
SIGNATURE <u>Elmer G. Linhardt</u>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>April 24, 1955</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>

23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>April 28, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
DATE REC'D BY LOCAL REG. <u>April 28, 55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Ben L. Hopping and Son</u>	ADDRESS <u>Annapolis, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

MAY 2 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03324

3311

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ANNE ARUNDEL		MARYLAND		STATE MARYLAND		COUNTY ANNE ARUNDEL	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS			
HOSPITAL OR INSTITUTION OR STREET ADDRESS BAY RIDGE RD.				STREET ADDRESS (If rural give location) BAY RIDGE RD.			
3. NAME OF DECEASED (Type or Print) ANTHONY J SEDLACEK				4. DATE OF DEATH (Month) (Day) (Year) APRIL 19, 19 55			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Sept. 27, 1886		9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Sedlacek				14. MOTHER'S MAIDEN NAME Catherine Hronek			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Mrs. Mazie Marie Sedlacek-wife- # 2			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4343 IMMEDIATE CAUSE (A) Heart disease				INTERVAL BETWEEN ONSET AND DEATH Sudden			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4/19, 19 55, to 4/19, 19 55, that I last saw the deceased alive on 4/19, 19 55, and that death occurred at 7 M, from the causes and on the date stated above.							
SIGNATURE Elmer G. Linhardt				ADDRESS (Street, city, town, state) Annopolis, Maryland			
DATE SIGNED 4-19-55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4-22-1955		NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		LOCATION (City, town, or county) Annopolis, Maryland	
24. REC'D BY REGISTRAR DATE 4-20-55		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> HOPPING FUNERAL HOME Annopolis, Md.			

3311 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

RECORDED

INDEXED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSE.

BUREAU V. S.

APR 25 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 103325
3340 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Ferndale</i>		<i>5 years</i>		TOWN <i>Pasadena</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Hammonds Ferry Road.</i>				(If rural give location)			
3. NAME OF DECEASED: (First) <i>Ladie</i> (Middle) <i>Hall</i> (Last) <i>Smith</i>				4. DATE OF DEATH: (Month) <i>April</i> (Day) <i>16</i> (Year) <i>1955</i>			
5. SEX: <i>F.</i>		6. COLOR OR RACE: <i>Colored</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>single</i>		9. AGE last birthday: <i>55</i> yrs.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <i>housework</i>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Anne Arundel County, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Arthur Hall</i>				14. MOTHER'S MAIDEN NAME: <i>Mary Snowden</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <i>Mrs. Kertie Hall (sister)</i>			

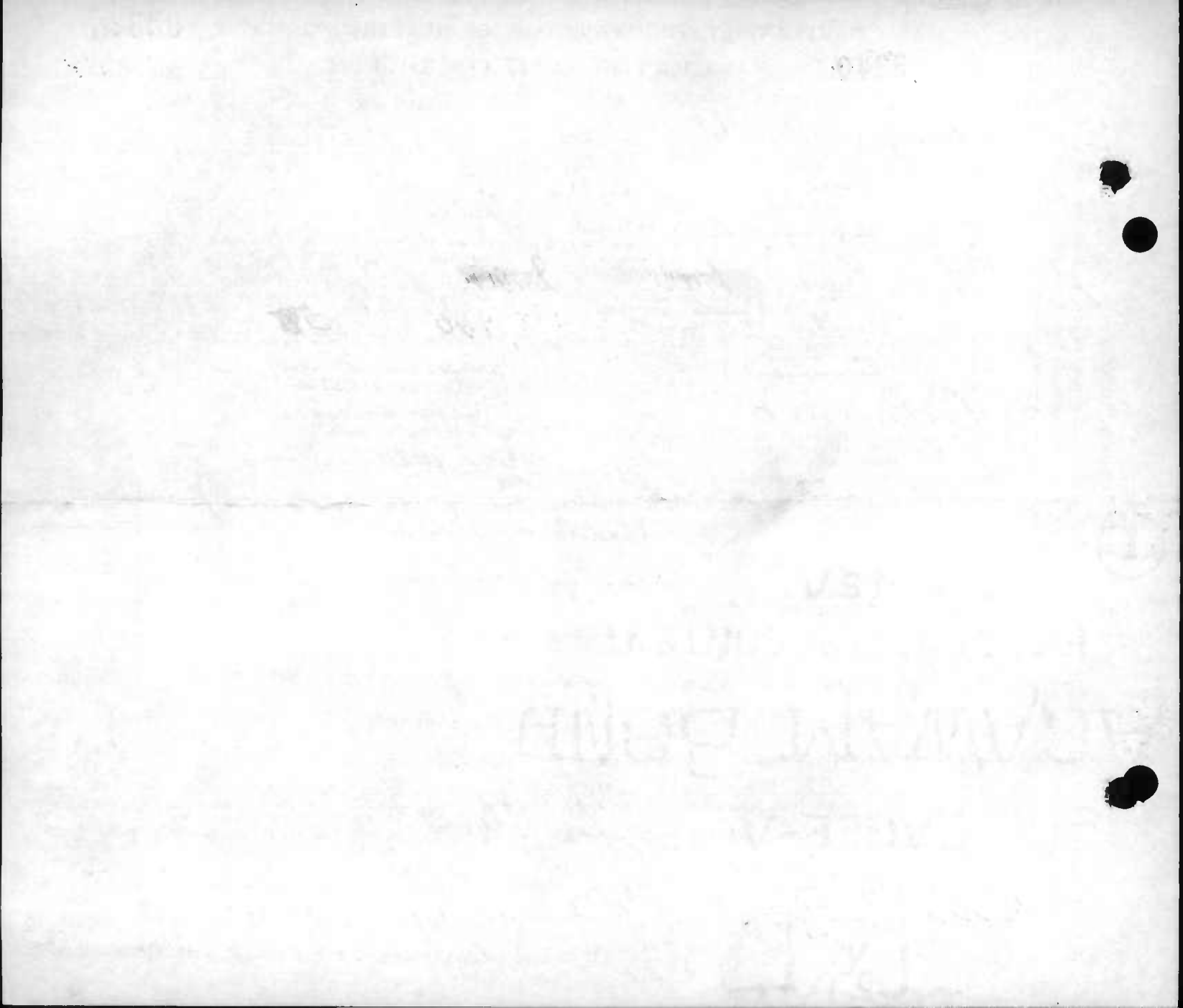
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<i>593X</i> Immediate cause (a) <i>Myocardial Insufficiency</i> Antecedent causes (s) (b) <i>Intestinal Nephritis</i> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>4/8/55</i> , 19 <i>55</i> , to <i>4/14/55</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>4/15</i> , 19 <i>55</i> , and that death occurred at <i>12:00 P.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>Klaus J. Paucke, M.D.</i>		(Degree or title)		ADDRESS <i>Blow Buena, Md.</i>		DATE SIGNED <i>4/16/55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <i>4/20/1955</i>		NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cem.</i>		LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>4-19-55</i>		REGISTRAR'S SIGNATURE <i>A. W. Dedrick</i>		24. FUNERAL DIRECTOR <i>Mr. Kate Williams</i>		ADDRESS <i>Schroeder St.</i>	

JSI

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3341

CERTIFICATE OF DEATH

03326

Reg. Dist. No. 24

Item 9 Film GL80 4-22-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>Md.</u> COUNTY <u>Balto.</u>		CITY <u>GLEN BURNIE</u>		CITY <u>GLEN BURNIE</u> COUNTY <u>Balto.</u>	
CITY <u>GLEN BURNIE</u>		LENGTH OF STAY <u>1</u> (in this place)		CITY <u>GLEN BURNIE</u>		CITY <u>GLEN BURNIE</u> COUNTY <u>Balto.</u>	
TOWN <u>GLEN BURNIE</u>		TOWN <u>GLEN BURNIE</u>		TOWN <u>GLEN BURNIE</u>		TOWN <u>GLEN BURNIE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MANOR CONV. HOME</u>				STREET ADDRESS <u>unknown</u> (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>FERDINAND J. SNYDER</u>				4. DATE OF DEATH <u>April 1 1955</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH <u>Oct 1-1898</u>	
9. AGE last birthday <u>56</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Machinist</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>WILLIAM SNYDER</u>				14. MOTHER'S MAIDEN NAME <u>ALICE JORDAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>				16. SOCIAL SECURITY NO. <u>12-325467</u>			
17. INFORMANT & ADDRESS <u>SON WILLIAM SNYDER</u>				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
420.0 IMMEDIATE CAUSE (A) <u>CEREBRO-VAICULAR ACCIDENT</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>CEREBRAL THROMBOSIS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>ARTERIOSCLEROTIC Heart Disease</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>and generalized Arteriosclerosis</u>							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/29</u> , 19 <u>55</u> , to <u>4/1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/31</u> , 19 <u>55</u> , and that death occurred at <u>5 p.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>John M. Vahr</u>				DATE SIGNED <u>4/1/1955</u>			
ADDRESS (Street, city, town, state) <u>102 BALTO-TIMAR BLVD. MC. GLEN BURNIE, MD.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>April 4-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Catherine's Cm.</u>		LOCATION (city, town, or county) (State) <u>Frederick</u>	
24. REC'D BY REGISTRAR <u>April 3 53</u>		REGISTRAR'S SIGNATURE <u>L. J. DeBaltis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick</u>		ADDRESS <u>5246 Carroll Ave.</u>	

RECEIVED

3312

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03327
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN Annapolis				TOWN Annapolis			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anna Arundel General Hospital				STREET ADDRESS (If rural, give location) Shady Oak			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
CLIMENT JOSEPH STALLINGS				APRIL 24, 19 55			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single		8. DATE OF BIRTH: Nov. 13, 1930	
				9. AGE last birthday: 24 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Driver-salesman Dry-cleaners				11. BIRTHPLACE (State or foreign country): Calvert County, Maryland			
10b. KIND OF BUSINESS OR INDUSTRY: Dry-cleaners				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME: Norwood Stallings				14. MOTHER'S MAIDEN NAME: Ella Hall			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes Korean				16. SOCIAL SECURITY No.: 213-28-1452			
				17. INFORMANT & ADDRESS: Mr Norwood Stallings-Father- same as # 2			

18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
Immediate cause (a) Ruptured Kidney		DUE TO	
Antecedent cause(s) (b) Secondary hemorrhage		DUE TO	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: 4-23-55		19b. MAJOR FINDING OF OPERATION: Ruptured Kidney	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Street	
21c. (City or town) (County) (State) Annapolis, Anne Arundel, Maryland			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 4-16-55 A M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR? Auto Accid			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE [Signature]		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4-24-55	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 4-26-1955	
NAME OF CEMETERY OR CREMATORY Nt Harmony Cemetery		LOCATION (City, town, or county) (State) Calvert County, Maryland	
DATE REC'D BY LOCAL REG. Apr. 25, 1955		24. FUNERAL DIRECTOR ADDRESS W.H. Hutchins and Sons Owings, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

2012

MEMORANDUM FOR THE DIRECTOR OF THE BUREAU OF INVESTIGATION

TO : DIRECTOR, BUREAU OF INVESTIGATION

FROM : SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 10/18/50

REFERENCE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

BUREAU V. S.

APR 28 1955

RECEIVED

3342

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Fort George G. Meade		3 Years		TOWN Pasadena		X /	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Army Hospital				STREET ADDRESS (If rural give location) Rt.#4, Box 16-A			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) DAVID		(Middle) KENNETH		(Last) STEWART		(Month) (Day) (Year) April 17 19 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Single	16 April 1955		Months	Days	Hours Min. 26
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					Maryland		USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Donald Gerald Stewart				Margie Loretta Rolley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Mother-same as #2			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Cerebral anoxia						INTERVAL BETWEEN ONSET AND DEATH Approx 26 hrs	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C) Prolonged resuscitation at birth							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 16 April, 19 55 , to 17 April, 19 55 , that I last saw the deceased alive on 17 April, 19 55 , and that death occurred at 0920 M, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
ROBERT M. MOORE <i>Robert Moore M.D.</i>				Fort George G. Meade, Maryland 17 Apr 55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		18 Apr 55		Post Cemetery		Fort G. G. Meade, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 18 Apr 1955		A.J. COMBOSH, CAPT. MSC		Chaplain Quigley Ft. G. G. Meade, Md.			

2045211405

INSTRUCTIONS

1 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

3313

Reg. Dist. No. 33

1. USUAL RESIDENCE (House or Apartment)

NAME: **JOHN J. HARRIS**
 SEX: **Male**
 AGE: **68**
 RACE: **White**

2. PLACE OF DEATH

NAME: **St. Mary's Hospital**
 ADDRESS: **1101 North Wolfe Street, Baltimore, Md.**

3. DATE OF DEATH

April 17, 1955

4. TIME OF DEATH

10:30 AM

5. CAUSE OF DEATH

Myocardial Infarction

6. MEDICAL HISTORY

None

7. MANNER OF DEATH

Natural

8. SIGNATURE OF PHYSICIAN

Dr. J. H. Harris

9. SIGNATURE OF REGISTRAR

John J. Harris

10. PLACE OF BIRTH

Baltimore, Md.

11. DATE OF BIRTH

April 17, 1955

BUREAU V. S.

APR 20 1955

RECEIVED

John J. Harris
Chaplain, St. Mary's Hospital

John J. Harris
Registrar

John J. Harris
Physician

ENCLOSURE

This is to certify that the above named person died on the day of the month of the year at the place of death stated above. The cause of death is as stated above. The manner of death is as stated above. The date of birth is as stated above. The place of birth is as stated above. The signature of the physician is as stated above. The signature of the registrar is as stated above. The signature of the chaplain is as stated above.

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A5C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3343

CERTIFICATE OF DEATH

03329

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Millersville, (Rural)</u>		LENGTH OF STAY (In this place) <u>90 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Millersville, (Rural)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100</u>				STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Charles W. Stinchcomb</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 25, 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 31, 1864</u>	9. AGE last birthday <u>90</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nelson Stinchcomb</u>				14. MOTHER'S MAIDEN NAME <u>Ann Martin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Oliver Stinchcomb, Millersville, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
450.0 IMMEDIATE CAUSE (A) <u>General Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10y.</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>Right inguinal hernia</u>						<u>5y.</u>	
C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>October 19, 1954</u> , to <u>4/25, 1955</u> , that I last saw the deceased alive on <u>4/24/55</u> , 19_____, and that death occurred at <u>1 A.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Buster K. Paulson</u>				ADDRESS (Street, city, town, state) <u>Glen Burnie Md.</u>		DATE SIGNED <u>4/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 27, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Stinchcomb Family Cemetery</u>		LOCATION (City, town, or county) (State) <u>Millersville, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>4/28/55</u> <u>April 26, 1955</u>		REGISTRAR'S SIGNATURE <u>Katherine M. Joyce</u> <u>R. D. Alba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Kirkley</u> <u>Hopping & Kirkley, Glen Burnie, Md.</u>			

CERTIFICATE OF DEATH

3843

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

05320

1955

1. Usual Residence (House or Apartment)

2. Place of Death

3. Date of Death

4. Time of Death

5. Cause of Death (Immediate)

6. Cause of Death (Underlying)

7. Manner of Death

8. Date of Burial

9. Place of Burial

10. Age

11. Sex

12. Race

13. Occupation

14. Education

15. Marital Status

16. Previous Illnesses

17. Present Illnesses

18. Date of Admission to Hospital

19. Date of Discharge from Hospital

20. Date of Death (Revised)

21. Cause of Death (Revised)

22. Manner of Death (Revised)

23. Date of Death (Final)

BUREAU V. S.

APR 28 1955

RECEIVED

APR 28 1955

APR 28 1955

RECEIVED

APR 28 1955

MARYLAND

3344

STATE DEPARTMENT OF HEALTH

03330

CERTIFICATE OF DEATH

Reg. Dist. No. 24

tem 9, Film G180 4-27-55 et

1. PLACE OF DEATH: COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Arnold md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>	
TOWN <u>Arnold md</u>		TOWN <u>Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Arnold md</u>		STREET ADDRESS (If rural, give location) <u>Broadwater Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>ETTA</u> (First) <u>A.</u> (Middle) <u>Todd</u> (Last)		4. DATE OF DEATH <u>APRIL 15 1955</u> (Month) (Day) (Year)	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>31 Aug. 1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE last birthday <u>76</u> yrs. (If under 1 year 12 months, Days, Hours, Min.)
13. FATHER'S NAME <u>Atlas Alexander</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>no</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
14. MOTHER'S MAIDEN NAME <u>MARIE Benedictine</u>		17. INFORMANT AND ADDRESS <u>Son: EDD Todd Arnold MD</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>443X</u>		(a) <u>Respiratory & Cardiac failure</u>	
Antecedent cause(s) <u>marked Hypertensive Cardio-Vascular disease</u>		(b) <u>disease</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) <u>Hypertension - Cerebral Thrombosis & Hemorrhage</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 25 March 1955 to 15 April 1955, that I last saw the deceased alive on 14 April 1955, and that death occurred at 07 PM m., from the causes and on the date stated above.

SIGNATURE Robert R. Halim (Degree or title) ADDRESS Severna Park 15 April 1955 DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>burial</u>	<u>April 16-55</u>	<u>Holy Cross Cemetery</u>	<u>Kelch Hgway Gt Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>April 18 1955</u>	<u>L. J. DeAlba</u>	<u>Bernard G. Fink</u>	<u>Blair Burnside Rd</u>

BUREAU V. S.

APR 21 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03331WC

3313

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A A</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>A A</u>	
CITY (If outside corporate limits, write RURAL or end give nearest town) TOWN <u>ANNAPOLIS</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>FRIENDSHIP</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>63 ANNE ARUNDEL GENERAL</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>BLANCHE VIOLA</u> (First) <u>WEBB</u> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>4-19-55</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, SEPARATED <u>MARRIED</u>	8. DATE OF BIRTH <u>9-9-1906</u>	9. AGE last birthday <u>48</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>SHADY SIDE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM C. WILDE</u>				14. MOTHER'S MAIDEN NAME <u>HILLIE EDGAR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>KENNETH C. WEBB (2)</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				II. MEDICAL CERTIFICATION			
175X IMMEDIATE CAUSE (A) <u>Pulmonary edema</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Heart failure</u>				5-6 mos.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Coarctation - debility</u>				16-18 mos.			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Carcinoma ovary, Carcinoma</u>							
19a. DATE OF OPERATION <u>Nov. 1953</u>		19b. MAJOR FINDINGS OF OPERATION <u>extensive Carcinoma ovary</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/19/55</u> to <u>4/19/55</u> , that I last saw the deceased alive on <u>4/19/55</u> and that death occurred at <u>10:35 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Heath Chihey</u>				ADDRESS (Street, city, town, state) <u>69 Franklin - 4/21/55</u>		DATE SIGNED <u>4/21/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-22-55</u>		NAME OF CEMETERY OR CREMATORY <u>Friendship Cent</u>		LOCATION (City, town, or county) (State) <u>Friendship Md.</u>	
24. REC'D BY REGISTRAR <u>JO - O. Daniel</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		ADDRESS <u>Sum Annapolis Md.</u>	
DATE <u>April 22, 1955</u>							

CERTIFICATE OF DEATH

1913

REG. NO. 100

DECEASED'S NAME (PRINTED)

AGE

FRANKLIN C. WILDE

PLACE OF BIRTH

STATE

DATE OF BIRTH

DECEASED'S SEX

DECEASED'S OCCUPATION

DECEASED'S MARITAL STATUS

DECEASED'S RELIGION

DECEASED'S RACE

DECEASED'S COLOR

DECEASED'S COMPLEXION

DECEASED'S HAIR

DECEASED'S EYES

DECEASED'S MOUTH

DECEASED'S NOSE

DECEASED'S EARS

DECEASED'S TEETH

DECEASED'S SKIN

DECEASED'S FINGERS

DECEASED'S TOES

DECEASED'S NAILS

DECEASED'S HAIR

DECEASED'S EYES

DECEASED'S MOUTH

DECEASED'S NOSE

DECEASED'S EARS

DECEASED'S TEETH

DECEASED'S SKIN

DECEASED'S FINGERS

DECEASED'S TOES

DECEASED'S NAILS

BRANCHES 1000 WEBB

FRANK WILDE MARRIED 9-9-1906 48

HOUSE WIFE HOME 2000 2000

FRANK WILDE

KENNETH C. WEBB

FRANK WILDE

FRANK WILDE

FRANK WILDE

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FRANK WILDE

RECEIVED
APR 25 1955
BUREAU V. J.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03332
3345 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY A. A.	MARYLAND	STATE Md.	COUNTY A. A.
CITY (If outside corporate limits, write TOWN and give nearest town) X Pasadena	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write TOWN and give nearest town) Pasadena	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) R. F. D. #6	

3. NAME OF DECEASED: (First) JOHN (Middle) PHILIP (Last) WEIMAN		4. DATE OF DEATH: (Month) Apr. (Day) 3, (Year) 1955	
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: June 25, 1948
9. AGE last birthday: 6 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired: none		10b. KIND OF BUSINESS OR INDUSTRY: none	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Frank P. Weiman		14. MOTHER'S MAIDEN NAME: Bernadette Gollery	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no		16. SOCIAL SECURITY No.: none	
17. INFORMANT & ADDRESS: Mr. Frank P. Weiman-Pasadena, Md.			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
2041 Immediate cause (a) Acute myelogenous leukemia		6 months
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO		
(c)		

11. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY ? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> HOW DID INJURY OCCUR ?	

22. I hereby certify that I attended the deceased from Sept. 22, 1954, to April 3, 1955, that I last saw the deceased alive on April 3, 1955, and that death occurred at 2:00 P.M., from the causes and on the date stated above.

SIGNATURE R. M. McLaughlin M.D. ADDRESS Pasadena, Md. DATE SIGNED April 3, 1955

23. BURIAL, CREMATION, REMOVAL (Specify) Burial	DATE THEREOF 4/6/55	NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	LOCATION (City, town, or county) Balto., Md.
DATE REC'D BY LOCAL REGISTRAR 4-4-55	REGISTRAR'S SIGNATURE R. W. Hedrick	24. FUNERAL DIRECTOR J. J. Tichenor & Sons	ADDRESS Balto 17, Md

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6/1/77

10/1/77

10/1/77

10/1/77

10/1/77

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3314

CERTIFICATE OF DEATH

Items B, 9: Film 6180 4-22-55L

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>ANNAPOLIS</u>				TOWN <u>ANNAPOLIS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>320 Sixth St.</u>				STREET ADDRESS (If rural give location) <u>320 Sixth St.</u>			
3. NAME OF DECEASED (Type or Print) <u>ANNIE HOLLAND WHEELER</u>				4. DATE OF DEATH <u>4-7-55</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widow</u>		8. DATE OF BIRTH <u>12/19/1877</u>	
9. AGE last birthday <u>83-72</u> yes		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT HOLLAND</u>				14. MOTHER'S MAIDEN NAME <u>HONORABLE HOGAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>GERALDINE WHEELER #2</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, generalized</u>				<u>unknown</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-26</u> , 19 <u>55</u> , to <u>4-7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4-7</u> , 19 <u>55</u> , and that death occurred at <u>12:05 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Edward J. Beck</u>		M.D. <u>4/4/55</u>		ADDRESS (Street, city, town, state) <u>4/4/55</u>		DATE SIGNED <u>4/7/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>4/8/55</u>		NAME OF CEMETERY OR CREMATORY <u>CEDAR Bluff</u>		LOCATION (City, town, or county) <u>ANNAPOLIS MD.</u>	
24. REC'D BY REGISTRAR <u>JO - J. J. J.</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR & SONS</u>		ADDRESS <u>ANNAPOLIS MD.</u>	
DATE <u>April 14, 1955</u>							

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

1. NAME OF DECEASED

Robert Wheeler

Age 42

Sex Male

Married

Wife

Robert Wheeler

Wife

Wife

Wife

Wife

Robert Wheeler

BUREAU V. S.

APR 13 1955

RECEIVED

COOR 3/11/55

John H. Taylor, Jr.

3346

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

03334

Reg. Dist. No. 21

1. PLACE OF DEATH - COUNTY <u>A. A. Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>A. A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Poplar Ridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Poplar Ridge</u>	
TOWN <u>Poplar Ridge</u>		TOWN <u>Poplar Ridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Poplar Ridge Road</u>		STREET ADDRESS (If rural, give location) <u>Poplar Ridge Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Arthur S. White</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 22 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 25, 1878</u>
9. AGE last birthday <u>76</u> yrs.		10. If under 1 year Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James H. White</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Ransley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Bessie White - Sister</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Arteriosclerosis Cardiovascular System</u>		<u>10 years</u>
Antecedent cause(s) (b) <u>Coronary Artery Disease</u>		<u>1 year</u>
(c) <u></u>		

II. OTHER SIGNIFICANT CONDITIONS	
Conditions contributing in the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
------------------------	----------------------------------	---

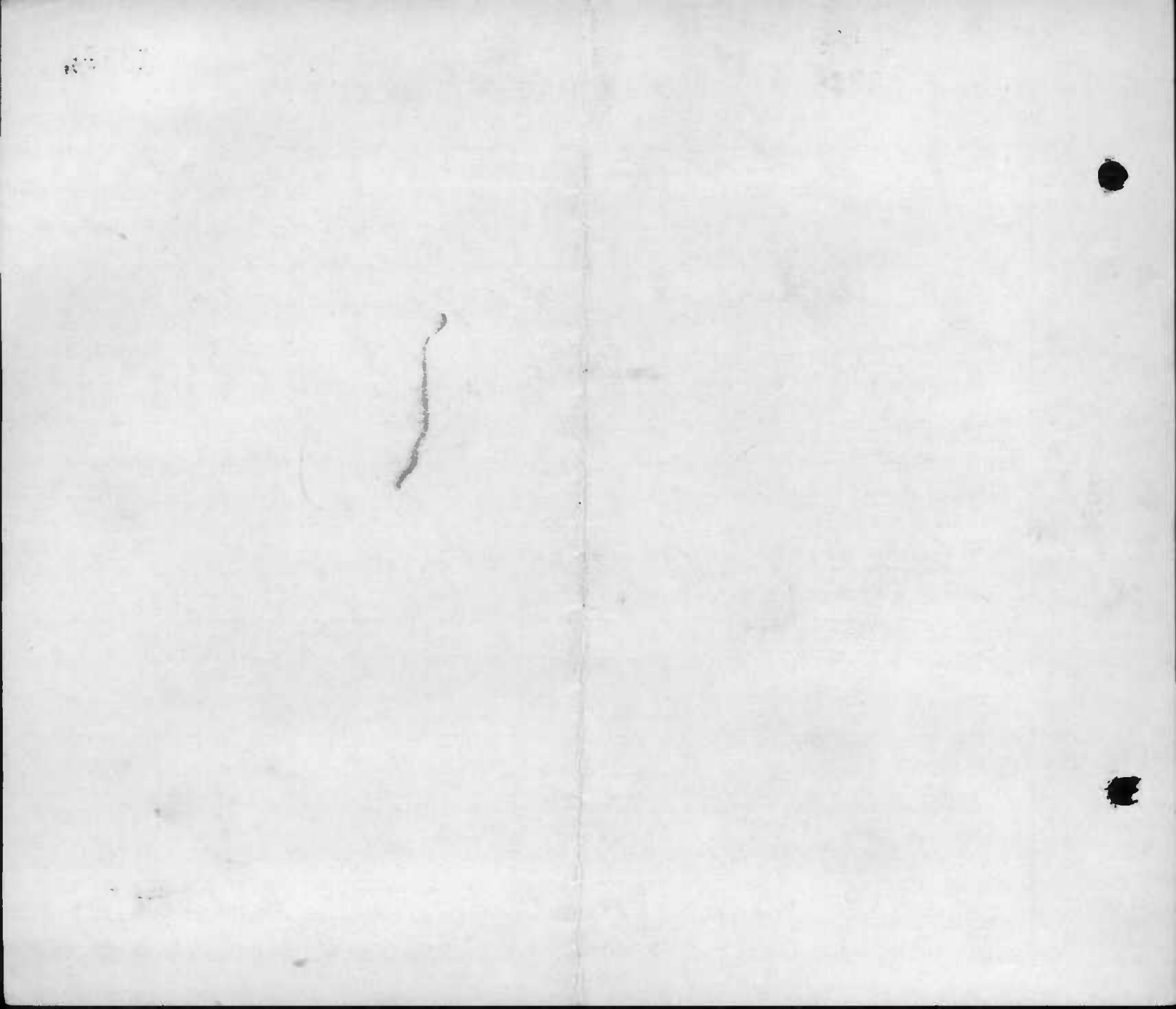
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
SIGNATURE <u>J. Brady Smith M.D.</u>	ADDRESS <u>Purina Beach, Md.</u>	DATE SIGNED <u>4/23/55</u>

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/26/55</u>	NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery Woodlawn Md.</u>	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. <u>4-25-55</u>	REGISTRAR'S SIGNATURE <u>A.W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Wm. Cook, Inc.</u>	ADDRESS <u>121 7th Bldg.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3347

CERTIFICATE OF DEATH

03335

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Crownsville</u>		<u>6 mos. 13 da.</u>		TOWN <u>Baltimore</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>2038 McCulloh St.</u>			
3. NAME OF DECEASED (Type or Print) <u>Julia B. White</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 15, 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William McCoy</u>				14. MOTHER'S MAIDEN NAME <u>Abbie Burns</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Hypertensive & Arteriosclerotic Cardiovascular Ds.</u>				INTERVAL BETWEEN KNOWN AND DEATH <u>since 10/2/54</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Cerebral Arteriosclerosis</u>				Known to us since 10/2/54			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Brain Syndrome assoc. with Cerebral Arteriosclerosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/2</u>, 19 <u>54</u>, to <u>4/15</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>4/15</u>, 19 <u>55</u>, and that death occurred at <u>7:30 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Stanley C. Sargent</u> M.D.				ADDRESS (Street, city, town, state) <u>Crownsville, Md</u>		DATE SIGNED <u>4/16/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/20/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Park</u>		LOCATION (City, town, or county) <u>Balto. Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Katherine M. Jones</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall P. Hayes</u>		ADDRESS <u>638 N. Belmon, Balt. Md</u>	
DATE <u>4/26/55</u>							

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 15, 1910	
Place of Birth		Cause of Death		Manner of Death		Occupation	
Baltimore, Md.		Heart Disease		Natural		Teacher	
Date of Death		Time of Death		Place of Death		Physician	
April 10, 1955		10:30 AM		Home		Dr. J. Smith	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

APR 26 1955

RECEIVED

Vertical text on the right edge of the page, likely a filing or processing stamp.

3348

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>A.A.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<i>X</i> TOWN <i>Marley</i>		<i>9 weeks</i>		<i>X</i> TOWN <i>Riviera Beach</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<i>100 P.O. Annapolis Road</i>				<i>Kenwood Road</i>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) (Middle) (Last)				OF DEATH: <i>April 28 1955</i>			
<i>Katie Wells White</i>							
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<i>FEMALE</i>		<i>WHITE</i>		<i>Single</i>		<i>June 9, 1868</i>	
				9. AGE last birthday		IF UNDER 1 YEAR	
				<i>86 yrs.</i>		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<i>Packer</i>				<i>Department Store</i>		<i>Vermont</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Wells Murray White</i>				<i>Eleanor Miranda Sexter</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<i>no</i>				<i>212-16-9383</i>		<i>Eleanor Glatman - Riviera Beach Md.</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 IMMEDIATE CAUSE		
(A) DUE TO <i>Coronary Artery Disease</i>		<i>2 months</i>
ANTECEDENT CAUSE (S)		
(B) DUE TO <i>Arteriosclerotic Cardio-Vascular Disease</i>		<i>10 years</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
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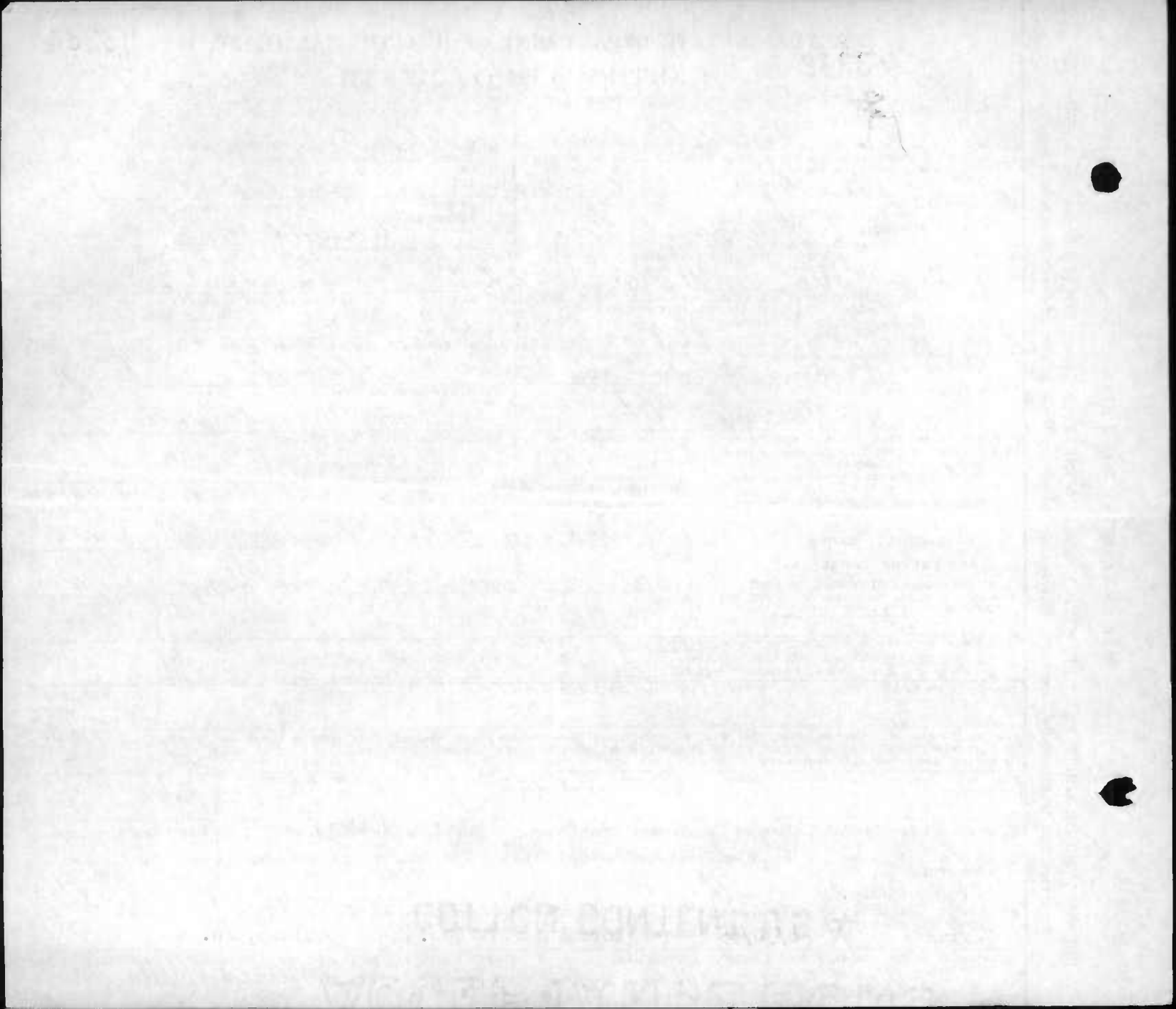
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from *June*, 1952, to *April 28, 1955*, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.

SIGNATURE <i>G. Brady Smith</i>	M.D. <i>Riviera Beach Md.</i>	DATE SIGNED <i>4/28/55</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<i>Burial</i>	<i>4/30/55</i>	<i>Lorraine Park Cem.</i>
		LOCATION (City, town, or county) (State)
		<i>Woodlawn, Md.</i>

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<i>4-29-55</i>	<i>W. H. Redner</i>	<i>Wm. J. Fickens & Sons</i>	<i>Bethesda Md.</i>

MARGIN RESERVED FOR BINDING



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3349
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

05277

Reg. Dist. *2*

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Laurel, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Laurel Race Track</u>				STREET ADDRESS (If rural, give location) <u>Allen's Motel</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CLARENCE ANDREW WINGATE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 27, 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH: <u>55</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>U</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>U</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>N</u>				14. MOTHER'S MAIDEN NAME: <u>N</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>O</u>		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>W</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>420.1</u> Immediate cause (a) <u>Coronary artery disease</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>R. F. Fisher</u>		M. D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4/29/55</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Embalanced</u>		DATE THEREOF <u>June 7, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Univ. of Maryland Med. Sch., Balt., Maryland</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>June 9, 1955</u>		REGISTRAR'S SIGNATURE <u>Cara Pasch</u>		24. FUNERAL DIRECTOR <u>The Anatomy Branch, Maryland</u>		ADDRESS <u>see: M. Christie</u>	

BUREAU V. S.

JUN 10 1955

RECEIVED

3350

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

03357

Reg. Dist. No. 26

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Pr. Geo's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL-Tracy's Landing-Transient</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Upper Marlboro</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>George</u>	(Middle) <u>Augustus</u>	(Last) <u>Wyvill</u>
4. DATE OF DEATH	(Month) <u>April</u>	(Day) <u>5</u>	(Year) <u>1955</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 8, 1895</u>
9. AGE last birthday <u>59</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11. CITIZEN OF WHAT COUNTRY? <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph V. Wyvill</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Purdy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes. W.W.I</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Beatrice Wells Wyvill-</u>		<u>Upper Marlboro, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

420.1 coronary thrombosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATHPLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY farm

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY 4 8 1955 8:15m.INJURY OCCURRED While at work ☒ Not while at work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☐

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Emily H. Wilson M.D.Lothian, Md.4-7-55

23. RIAL CREMATION (Specify)

DATE THEREOF 4/11/55NAME OF CEMETERY OR CREMATORY Mt. Carmel CemeteryLOCATION (City, town, or county) Upper Marlboro(State) Md.

DATE RECEIVED BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

April 14J. B. BentRitchie Brothers Upper Marlboro, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 15 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE AR UNDEL</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Balti. city</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>GLEN BURNIE</u>		LENGTH OF STAY (in this place) <u>2 1/2 mo</u>		CITY (If outside corporate limits, write RURAL end give nearest town) <u>Baltimore</u>		COUNTY <u>3V01.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Plaza Maria Nanning Home 10306 A-RT-2, Glen Burnie</u>		STREET ADDRESS (If rural give location) <u>1912 W. Saratoga St.</u>					
3. NAME OF DECEASED (Type or Print) <u>WILLAS (N) YARBROUGH</u>				4. DATE OF DEATH <u>APR. 9 19 55</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>COL.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WID.</u>		8. DATE OF BIRTH <u>25 June 1880</u>	
9. AGE last birthday <u>74</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tanner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher</u>		11. BIRTHPLACE (State or foreign country) <u>Louisville, Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>yes</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>unk.</u>		17. INFORMANT & ADDRESS <u>Mr. Rachel VINES (niece) 1912 W. Saratoga St. Balt., Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) <u>arteriosclerotic Heart Disease</u>						7 yrs	
ANTECEDENT CAUSE(S) DUE TO (B) <u>General arteriosclerosis</u>						10 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>none</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>none</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>none</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>none</u>			
22. I hereby certify that I attended the deceased from <u>apr. 9</u> , 19 <u>55</u> , to <u>apr. 9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>apr. 9</u> , 19 <u>55</u> , and that death occurred at <u>8:45 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>H-F Manuzak</u>		M.D. <u>901 Edgely Rd, Glen Burnie, Maryland</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>WED</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 13, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt Auburn</u>		LOCATION (City, town, or county) (State) <u>Balti</u>	
24. REC'D BY REGISTRAR <u>4/13/55</u>		REGISTRAR'S SIGNATURE <u>Louis Sedella</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph L Brown Son</u>		ADDRESS	

* Note: This patient was under care of Dr. J. T. Allen & Glen Burnie, 10306 W. Saratoga St.

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James

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BUREAU V. S.

APR 19 1965

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